

Employee Change Form

Employer/ COMPANY Name	Effective date of Change: (mmm/dd/yyyy)
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Employees Last & First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mmm/dd/yyyy)
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Policy/Group #:	Division Name:	Cert #:	EMPLOYER ISSUED ID #: <small>(IF APPLICABLE)</small>
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Reason for Change:	<input type="checkbox"/> Terminate this employee	<input type="checkbox"/> Change coverage to single	<input type="checkbox"/> Change coverage to family
	<input type="checkbox"/> Reinstate employee	<input type="checkbox"/> Delete a dependent	<input type="checkbox"/> Add a new dependent
	<input type="checkbox"/> Address change	<input type="checkbox"/> Employee/Dependent Name change	
	<input type="checkbox"/> HCSA Maximum change	<input type="checkbox"/> Add or Remove Spouse's other insurance provider (AOB)	

Address Change:	
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Health Spending Account Maximum Change (HCSA):	New ANNUAL maximum	Effective date of Change	
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Coverage Change:

Spouse/Dependent Information				
Last & First Name	Date of Birth <small>(mmm/dd/yyyy)</small>	Relationship (spouse, son, daughter, etc.)	Is s/he attending full time post-secondary education?	Type of Change
				<input type="checkbox"/> Add <input type="checkbox"/> Remove
				<input type="checkbox"/> Add <input type="checkbox"/> Remove
				<input type="checkbox"/> Add <input type="checkbox"/> Remove
				<input type="checkbox"/> Add <input type="checkbox"/> Remove


Name Change:	
Employee	From _____ To _____
Dependent	From _____ To _____

Spouse's Coverage Change:					
Indicate your spouse's coverage with his/her employer					Policy #:
Health	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Waived	<input type="checkbox"/> None	Insurance Provider Name:
Dental	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Waived	<input type="checkbox"/> None	
Vision	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> Waived	<input type="checkbox"/> None	

Protecting your personal information: At ProBenefits Inc., we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of ProBenefits or the offices of an organization authorized by ProBenefits. We limit access to personal information to your file to ProBenefits staff or persons authorized by ProBenefits who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

Name of Employee (PLEASE PRINT)	Signature of Employee	Date

Plan Administrator (PLEASE PRINT)	Signature of Administrator	Date

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