NORTHERN EMPLOYEE BENEFITS SERVICES

5122 53rd Street, Yellowknife NT, X1A 1V6
Ph: (867) 873-4965 Fax: (867) 873-5801

INFORMATION CHANGE FORM

GROUP INSURANCE AND HEALTH BENEFITS

PLEASE PRINT CLEARLY IN BLUE INK AND RETURN ORIGINAL SIGNED FORM TO THE NEBS OFFICE.

Employer Name: ______________________________

Employee Last Name: ______________________ Employee First Name: ______________________

Employee Address: ______________________________

Employee Phone Number: ______________________ Employee Email: ______________________

1. EMPLOYEE NAME CHANGE

Current Last Name: ______________________ Current First Name: ______________________

Previous Last Name: ______________________ Previous First Name: ______________________

☐ Single ☐ Married ☐ *Common Law Effective Date: ______________________

*PLEASE ATTACH MARRIAGE CERTIFICATE, LEGAL CHANGE IN NAME CERTIFICATE, COMMON-LAW DECLARATION OR DIVORCE AGREEMENT IN SUPPORT OF CHANGE.

2. SPOUSAL INFORMATION CHANGE

☐ Add Last Name: ______________________ First Name: ______________________

☐ Remove Birth Date: ______________ Sex: ________ Health Care Card Number: ______________________

☐ Married ☐ Common Law Effective Date: ______________________

☐ Add Last Name: ______________________ First Name: ______________________

☐ Remove Birth Date: ______________ Sex: ________ Health Care Card Number: ______________________

☐ Married ☐ Common Law Effective Date: ______________________

*PLEASE ATTACH MARRIAGE CERTIFICATE, LEGAL CHANGE IN NAME CERTIFICATE, COMMON-LAW DECLARATION OR DIVORCE AGREEMENT IN SUPPORT OF CHANGE.

**COMMON-LAW SPOUSE MEANS THAT I HAVE LIVED WITH THIS PERSON AS MY SPOUSE OR PARTNER FOR A CONTINUOUS PERIOD OF AT LEAST 12 MONTHS, AND I HAVE PUBLICLY REPRESENTED THIS PERSON TO BE MY COMMON-LAW SPOUSE.

REMOVING SPOUSE BENEFITS DOES NOT REMOVE THEM AS A BENEFICIARY. PLEASE FILL OUT A CHANGE OF BENEFICIARY FORM.

3. DEPENDENT INFORMATION CHANGE

☐ Add Last Name: ______________________ First Name: ______________________ Sex: ________

☐ Remove Birth Date: ______________________ Health Care Card Number: ______________________

☐ Natural ☐ Adopted ☐ Common Law* ☐ Student** ☐ Disabled Dependent***

☐ Add Last Name: ______________________ First Name: ______________________ Sex: ________

☐ Remove Birth Date: ______________________ Health Care Card Number: ______________________

☐ Natural ☐ Adopted ☐ Common Law* ☐ Student** ☐ Disabled Dependent***

* Your spouse's child is an eligible dependent if the child is also your natural or adopted child and your spouse is residing with you, insured under you plan and has custody of the child.

** You must notify NEBS if there are any changes in student status and you must submit a Declaration of Student Eligibility before June 30 prior to the academic year.

*** You are required to complete a Group Health Evidence questionnaire once the disabled dependent reaches the age of 21.

4. CHANGE IN OPTIONAL PLAN COVERAGE

REMOVAL OF BENEFITS

I understand the group benefits offered to me, but I decline:

☐ Extended Health Only ☐ Dental Only ☐ Extended Health & Dental ☐ Remove Family Coverage & Maintain Single Coverage

Spouse's Insurer: _____ Effective Date: _____

ADDITION OF BENEFITS

You may add Extended Health Care and/or Dental benefits if your spouse has recently become eligible, you had a child, or your spouse has lost coverage or have had a marriage breakdown.

Extended Health Care and Vision Care:	**Dental Care:**
☐ Employee Coverage ☐ Family Coverage ☐ Spouse Only	☐ Employee Coverage ☐ Family Coverage ☐ Spouse Only

Effective Date of Loss of Coverage Under Your Spouse's Plan: _____

If you participate in Extended Health and/or Dental Care you must participate at least one year. To add these benefits at a later date, you must apply within 31 days of loss of spousal coverage. After 31 days, proof of insurability may be required and coverage may be restricted, reduced, or denied. NEBS Plan coverage will be coordinated with other plans so that your benefits do not exceed 100% of actual allowable benefit.

5. PRIVACY AND PLAN MEMBER SIGNATURE

NORTHERN EMPLOYEE BENEFITS SERVICES PRIVACY STATEMENT: Northern Employee Benefits Services (NEBS) is committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

I hereby apply for plan coverage and authorize the remittance to NEBS of any contributions required under the plans. I hereby authorize NEBS and their Insurance Underwriters, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determination of eligibility and administration of the plans. I confirm I am authorized to act on behalf of my spouse and /or dependents for such purposes. I declare that the information provided is true, complete, and accurate. Any copy of this authorization shall be as valid as the original.

_____ _____

Member Name (Print) **Witness Name (Print)**

_____ _____

Member Signature **Witness Signature**

_____

Date