



Health Care Providers Group Insurance Plan PERSONAL INFORMATION CHANGE REQUEST

GREENSHIELD ID #: _____
 PLAN MEMBER NAME: _____

PART A— NAME CHANGE

REVISED LAST NAME: _____
 REASON FOR CHANGE: _____
 DOCUMENTATION TO SUPPORT CHANGE: _____
 Please attach a copy of the supporting document(s) with this completed form

MARRIAGE / DIVORCE / SEPARATION: Please complete Part B to add/remove a participant to/from the plan **OR** complete the spousal waiver declaration below.

My dependent spouse is currently covered for extended healthcare benefits under another group plan.
 Insurance Carrier: _____ Company/Organization: _____

PART B— ADD/REMOVE PARTICIPANT

| | | |
|--------|---------------|----------------------|
| ADD | REASON: _____ | DATE OF CHANGE _____ |
| REMOVE | REASON: _____ | DATE OF CHANGE _____ |

| RELATION | NAME | DATE OF BIRTH (DD/MM/YYYY) | GENDER M/F | FULL-TIME STUDENT AGE 21–25 |
|----------|------|-------------------------------|---------------|--------------------------------|
| | | | | |
| | | | | |
| | | | | |

PART C — CONTACT INFORMATION

REVISED MAILING ADDRESS: _____
 REVISED HOME PHONE NUMBER: _____
 REVISED MOBILE PHONE NUMBER: _____
 REVISED EMAIL ADDRESS: _____

PART D—BANKING INFORMATION

I wish to change the bank account from which the monthly premium withdrawals are made.

Please attach a copy of a VOID cheque from the new account to this completed form. Effective date of change will be dependent upon the time of the month which the request is made. Contact our offices for more information.

I authorize all changes requested above to be made to my account

SIGNATURE: _____ DATE: _____