Health Care Providers Group Insurance Plan
PERSONAL INFORMATION CHANGE REQUEST

C1

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 competed 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: _____

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