AGA BENEFIT SOLUTIONS

CONFIRMATION OF INFORMATION
COORDINATION OF BENEFITS

ADMINISTRATIVE INFORMATION

Employer/Policyholder name			Group No.
Employee's last name	First name		Certificate No.
Address (No. / Street / Apt.)			
City	Province	Postal code	Telephone

**Because you answered that your children were insured under another plan, please confirm the following details.
This information is necessary for the application of coordination of benefits rules.**

Child(ren) name(s) :: ______________________________

Health Care

☐ Coverage by the plan of current spouse
☐ Coverage by the plan of the other parent
☐ Coverage by the plan of the spouse of the other parent
☐ Coverage by the plan of the other parent and the spouse of the other parent
☐ Coverage by the plan of an educational institution:
☐ including drug coverage ☐ excluding drug coverage

If the parents are separated, divorced or not living together :
Are you the sole custodial parent? ☐ **or**
Does the other parent have sole custodial? ☐ **or**
Do you have shared custody? ☐
If you share custody, please indicate other parent's date of birth :
(YYYY/MM/DD) : ______________________

Dental Care

☐ Coverage by the plan of current spouse
☐ Coverage by the plan of the other parent
☐ Coverage by the plan of the spouse of the other parent
☐ Coverage by the plan of the other parent and the spouse of the other parent
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(YYYY/MM/DD) : ______________________

EMPLOYEE'S SIGNATURE

Employee's signature	Date (Y/M/D):