AGA BENEFIT SOLUTIONS

# NOTICE OF CHANGE IN COVERAGE

***All changes in employee status must be submitted within 31 days from the date of the event, if not, proof of insurability may be requested by the insurer***

## ADMINISTRATIVE INFORMATION

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

***Quebec Residents ☞ Before completing this section, please refer to the « BILL 33 » document on reverse***

## REQUIRED COVERAGE AND INFORMATION ON SPOUSE AND/OR CHILDREN

| | |
|---|---|
| Health care : | ☐ Single ☐ Single parent ☐ Couple ☐ Family ☐ Opt-out – Reason: _____ |
| Dental care: | ☐ Single ☐ Single parent ☐ Couple ☐ Family ☐ Opt-out – Reason: _____ |
| Dependent Life benefit: (if it is part of your plan) | Do you want to cover your dependent for Dependent Life benefit? ☐ Yes ☐ No (This benefit may be mandatory with some insurers if you have eligible spouse and/or children) |

### SPOUSE AND/OR CHILDREN IDENTIFICATION

***The Dependent Life benefit coverage, if part of your plan, may be mandatory with some insurers if you have eligible spouse and/or children. You must indicate all information regarding your eligible spouse and/or children even if you choose a "Single" coverage or if you choose to "Opt-out".***

| | Last name | First name | Sex M | Sex F | Date of birth ( YYYY - MM - DD ) | If aged 21 or older, please specify | | Are your spouse/children covered by another plan ? Health care Yes | Health care No | Dental care Yes | Dental care No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Spouse | | | ☐ | ☐ | | Full-time student | Handicapped | ☐ | ☐ | ☐ | ☐ |
| Child 1 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child 2 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child 3 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child 4 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child 5 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child 6 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child 7 | | | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**If you have answered « Yes » to the question: « Are your children covered by another plan? », please confirm details on the back of this page. This information is necessary to apply the rules for the coordination of benefits.**

| **LIFE EVENTS :** | | | |
|---|---|---|---|
| ☐ Marriage/civil union | | Date of marriage/civil union ➡ | ( YYYY - MM - DD ) |
| ☐ Common-law spouse | | Date of start of cohabitation ➡ | ( YYYY - MM - DD ) |
| ☐ Separation/divorce | | Date of separation/divorce ➡ | ( YYYY - MM - DD ) |
| ☐ Birth/adoption | | Date of birth/adoption ➡ | ( YYYY - MM - DD ) |
| ☐ Adding a full-time student child | Name : _____ | ➡ | ( YYYY - MM - DD ) |
| ☐ Decease | Name : _____ | ➡ | ( YYYY - MM - DD ) |
| ☐ End of eligibility of a dependent | Name: _____ | ➡ | ( YYYY - MM - DD ) |
| ☐ Coverage by the spousal/parent plan | | Start date of coverage ➡ | ( YYYY - MM - DD ) |
| ☐ End of coverage by the spousal/parent plan | | End date of coverage ➡ | ( YYYY - MM - DD ) |
| ☐ Involuntary end of spousal/parent coverage | | End date of coverage ➡ | ( YYYY - MM - DD ) |
| ☐ Coverage by an educational institution plan | | Start date of coverage ➡ | ( YYYY - MM - DD ) |
| ☐ Other : _____ | | Date of change ➡ | ( YYYY - MM - DD ) |

## EMPLOYEE'S SIGNATURE

| | |
|---|---|
| Employee's signature | Date |

**Children covered by another plan – Please provide the following details :**

**Indicate for which child the following applies – Child # :** _____

| **Health care** | **Dental care** |
|---|---|
| ☐ Coverage by the plan of current spouse<br>☐ Coverage by the plan of the other parent<br>☐ Coverage by the plan of the spouse of the other parent<br>☐ Coverage by the plan of the other parent and the spouse of the other parent<br>☐ Coverage by the plan of an educational institution:<br>☐ including drug coverage ☐ excluding drug coverage<br>***If the parents are separated, divorced or not living together :***<br>Are you the sole custodial parent? ☐ **or**<br>Does the other parent have sole custodial? ☐ **or**<br>Do you have shared custody? ☐<br>If you share custody, please indicate other parent's date of birth :<br>( YYYY/MM/DD ) : _____ | ☐ Coverage by the plan of current spouse<br>☐ Coverage by the plan of the other parent<br>☐ Coverage by the plan of the spouse of the other parent<br>☐ Coverage by the plan of the other parent and the spouse of the other parent<br>☐ Coverage by the plan of an educational institution:<br>☐ including drug coverage ☐ excluding drug coverage<br>***If the parents are separated, divorced or not living together :***<br>Are you the sole custodial parent? ☐ **or**<br>Does the other parent have sole custodial? ☐ **or**<br>Do you have shared custody? ☐<br>If you share custody, please indicate other parent's date of birth :<br>( YYYY/MM/DD ) : _____ |

**Indicate for which child the following applies – Child # :** _____

| **Health care** | **Dental care** |
|---|---|
| ☐ Coverage by the plan of current spouse<br>☐ Coverage by the plan of the other parent<br>☐ Coverage by the plan of the spouse of the other parent<br>☐ Coverage by the plan of the other parent and the spouse of the other parent<br>☐ Coverage by the plan of an educational institution:<br>☐ including drug coverage ☐ excluding drug coverage<br>***If the parents are separated, divorced or not living together :***<br>Are you the sole custodial parent? ☐ **or**<br>Does the other parent have sole custodial? ☐ **or**<br>Do you have shared custody? ☐<br>If you share custody, please indicate other parent's date of birth :<br>( YYYY/MM/DD ) : _____ | ☐ Coverage by the plan of current spouse<br>☐ Coverage by the plan of the other parent<br>☐ Coverage by the plan of the spouse of the other parent<br>☐ Coverage by the plan of the other parent and the spouse of the other parent<br>☐ Coverage by the plan of an educational institution:<br>☐ including drug coverage ☐ excluding drug coverage<br>***If the parents are separated, divorced or not living together :***<br>Are you the sole custodial parent? ☐ **or**<br>Does the other parent have sole custodial? ☐ **or**<br>Do you have shared custody? ☐<br>If you share custody, please indicate other parent's date of birth :<br>( YYYY/MM/DD ) : _____ |

Initials : _____

## *QUEBEC RESIDENTS ONLY*
## *BILL 33 - « DID YOU KNOW … »*

- ✓ *On January 1st, 1997, Bill 33 (Quebec Universal Drug Plan) became effective for all Quebec residents.*
- ✓ *All Quebec residents under 65 years of age that have access to a group insurance plan, are obliged to join the group plan. If a person is covered by another group plan or if a person is covered by a spouse's group plan, proof of such coverage must be filed with your employer.*
- ✓ *On the group insurance application form with your employer, you are obliged to insure all eligible dependents, spouse and children, unless these dependents are already covered by another group plan.*
- ✓ *Your eligible dependents cannot be insured with R.A.M.Q. (Quebec Universal Drug Plan) if you are covered by your employer's group plan, with the exception of a spouse, aged 65 years and over.*
- ✓ *When filing your Quebec tax return, you will be asked if you have met the requirements according to this law.*

***For further information, please do not hesitate to contact Customer Service at the following numbers :***

| | |
|---|---|
| ***Montreal area:*** | ***514-935-5444*** |
| ***Elsewhere in Quebec:*** | ***1 800 363-6217*** |
| ***Fax:*** | ***514-935-1147*** |