MEDIC SOLUTIONS
Group insurance, evolved

Participating Employee Change Form

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Medic Client Number		*** IMPORTANT - Medic Certificate Number**	

Employer's name

Participant name

Last name	First name	Telephone

EFFECTIVE DATE OF CHANGE: Day Month Year

Modification: ☐ **Addition of coverage** ☐ **Withdrawal of coverage**

Current protection / **HEALTH**

☐ Single ☐ Couple ☐ Single-Parent ☐ Family ☐ Exempted

Protection required / **HEALTH**

☐ Single ☐ Couple ☐ Single-Parent ☐ Family ☐ Exempted

Current protection / **DENTAL**

☐ Single ☐ Couple ☐ Single-Parent ☐ Family ☐ Exempted

Protection required / **DENTAL**

☐ Single ☐ Couple ☐ Single-Parent ☐ Family ☐ Exempted

Change in dependant coverage: ☐ **Added** ☐ **Deleted**

Last name		First name	
Relationship (Spouse, *child, other…)*	Gender (Male/ Female)	Date of birth Day Month Year	Age
Last name		First name	
Relationship (Spouse, child, other…)	Gender (Male/ Female)	Date of birth Day Month Year	Age
Last name		First name	
Relationship (Spouse, child, other…)	Gender (Male/ Female)	Date of birth Day Month Year	Age

Reason for change

☐ Marriage - Union date: Day Month Year

☐ Common Law - Date of cohabitation: Day Month Year

☐ Termination of my spouse's insurance Date: Day Month Year

Name of previous insurer: Policy number:

☐ Separation / Divorce Date: Day Month Year

☐ Other:

Exemption of benefit

If you or your spouse are currently covered for Health and/or Dental benefits under another group policy, you may refuse to be covered under this policy by completing the following:

Spouse's right of waiver

Medical expenses: ☐ Me AND my dependents ☐ My dependents only ☐ Others _____

Dental expenses: ☐ Me AND my dependents ☐ My dependents only ☐ Others _____

Name of previous insurer	Policy number	Medical fee ☐ Individual ☐ Family	Dental fee ☐ Individual ☐ Family	***Please provide us with a proof of coverage with the other insurer.**

A photocopy or electronic copy of this form and authorization will be as valid as the original.

Participating employee signature	Employer signature
Date (*dd/mm/yy*)	Date (*dd/mm/yy*)