MEDIC SOLUTIONS
Group insurance, evolved

PARTICIPATING EMPLOYEE CHANGE FORM

3542, Concorde Blvd East, suite 107, Laval (Quebec) H7E 4W1
Tel. : 514 360-1111 | Toll-free : 1 866 518-0633 | Fax : 514 316-3033

Reserved for Medic Solutions Medic Client No. _____ Medic certificate No. _____

Employer's name

Participant name

Last name	First name	Telephone

EFFECTIVE DATE OF CHANGE : (mm/dd/yyyy)

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 mm /dd /yyyy
Last name		First name
Relationship : (*Spouse, child, other*)	Gender (Male / Female)	Date of birth mm /dd /yyyy
Last name		First name
Relationship : (*Spouse, child, other*)	Gender (Male / Female)	Date of birth mm /dd /yyyy

Reason for change

☐ Marriage-Union date : ☐ Common Law-Date of cohabitation :

☐ Termination of my spouse's insurance Date : (mm/dd/yyyy)

Previous insurer : Policy number :

☐ Separation / Divorce Date : (mm/dd/yyyy)

☐ 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:
Waiver of supplementary health and/or dental insurance (spousal waiver)

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

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

Previous insurer*	Policy number*	Medical fee	Dental fee	
		☐ Individual ☐ Family	☐ 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 *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*

Reset form