To complete this form online, please open it in Adobe

ICBA BENEFITS

Amendment to Coverage Status
Apply or waive for EHC and/or Dental

Use this form:

- If you were enrolled for EHC and/or Dental, and now want to waive coverage because you've acquired coverage through another (e.g. spouse's) plan
- If you waived coverage for EHC and/or Dental, and now want to enroll because your other coverage terminated

Section 1 - Plan Sponsor / Employer complete this section

Note: Words in blue text are defined on page 2.

Organization	Policy No. / Client Code	Certificate No.
Employee Legal Last Name	Employee Legal First Name	O Application for ☐ EHC O Waiving coverage for ☐ Dental
Your Name and Title	Email address	Phone No.
Signature		Date Signed (mm/dd/yyyy)

Section 2 - Information about your other coverage. Employee complete this section

Insurance Company	Policy / Group No.	Type of Coverage ☐ EHC ☐ Dental	Cardholder O My Spouse O Other (specify)
Coverage O Single O Couple O Family	O Termination Date - Provide if you are applying for coverage (mm/dd/yyyy) O Effective Date - Provide if you are now waiving coverage		

Section 3 - Employees complete this section only if you are appyling for EHC and/or Dental coverage

Dependent Information - complete this section if you have a spouse/eligible children ☐ More than 4 children, attach list

	Legal Last Name	Legal First Name	Date of Birth (mm/dd/yyyy)	Gender	If over 21:
Spouse				O Male O Female O X	N/A
Child				O Male O Female O X	☐ Full-time Student ☐ Disabled
Child				O Male O Female O X	☐ Full-time Student ☐ Disabled
Child				O Male O Female O X	☐ Full-time Student ☐ Disabled
Child				O Male O Female O X	☐ Full-time Student ☐ Disabled

Section 4 – Employee complete this section only if you are waiving coverage

I understand the group benefits plan, but I am waiving coverage in:

Click here to clear Section 4

☐ EHC for O myself and my family O my spouse and children only

☐ Dental for: O myself and my family O my spouse and children only

Section 5 – Employee complete this section – Declaration and Authorization

If waiving coverage, I confirm that the person(s) I am waiving coverage for has/have coverage under another plan. I understand that my EHC/Dental coverage under this plan will stop on the date ICBA Benefits receives this completed form from me. I understand that I/my family may rejoin this plan at a later date if I/we apply within 31 days of the other plan cancelling; otherwise I/my family will be required to provide evidence of insurability, and our application may be declined.

If applying for coverage, I accept the policy's terms and conditions, and I authorize the necessary contributions to be made through payroll deductions, if applicable. I understand that coverage under this policy will be effective coincident with the termination date of my other coverage provided ICBA Benefits receives this completed form within 31 days of the other plan's termination date; otherwise I will be required to provide evidence of insurability for myself and my eligible dependents, and the insurance company may decline my/our application. I certify that I am covered, and my spouse and children (if applicable) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.

I authorize my employer and ICBA Benefits, the insurance company and its reinsurers, any healthcare provider, administrators of government benefits or other benefits programs to give, receive and share any personal information regarding my eligibility for coverage and to administer the plan, or those of my dependents, if applicable.

I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.

Signature	Date signed (mm/dd/yyyy)

Return completed form to ICBA Benefits via email (indicate the policy number in the Subject line), or by mail. If you email the form, do not also send the original by mail.

ICBA Benefit Services Ltd. - #800 - 13761 96th Avenue, Surrey, BC V3V 0E8

604.298.7752 TF: 1.888.298.7752 help@icbabenefits.ca icbabenefits.ca

Group Benefits
Decline or Apply for EHC and/or Dental

Instructions / Additional Information:

Policy No. / Client Code – Indicate either number as it appears on your monthly invoice.

Division / Billing Group No. – Provide only if your plan has multiple divisions or billing groups; otherwise leave blank. If applicable, the number will appear on your monthly invoice.

Class Code – Provide only if your plan includes a class number; otherwise leave blank.

Gender – Please indicate the gender on your government issued ID. For gender X, write "X". Note: the insurance company may require a gender of male or female for underwriting purposes.

If over 21 – To be covered on your plan beyond age 21, a child must either meet Canada Revenue Agency's criteria for a full-time student, or be disabled. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Other – Examples of Other plans, i.e. where the cardholder is not your spouse, include coverage you have through another employer or retiree plan. Please note, not all insurance companies will accept waivers/applications related to other coverage that is not a spouse's plan. We will let you know if your application / waiver is not accepted by the insurance company.

Section 4 – Coverage under the plan is mandatory, except if the employee or dependents are covered under another plan for EHC and/or Dental benefits. Complete this section only if you are waiving coverage for yourself or for yourself and your dependents because you/they are covered for EHC and/or Dental benefits under another plan.

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