Group Benefits
Employee Change Form

If applying for EHC and/or Dental benefits after previously waiving coverage, or declining coverage for these benefits after previously enrolling for them, complete *Decline or Apply for EHC and/or Dental* form.
To change your beneficiary, complete a *Beneficiary Designation* form.
To continue coverage for a child after age 21:

- If the child is a full-time student, complete a *Student Declaration* form
- If the child is disabled, contact us for the required form.

Section 1 – Complete this section

Organization/Company	Policy No. / Client Code	Certificate No.
Employee Legal Last name	Employee Legal First Name	Date of change (mm/dd/yyyy)

Section 2 – Employment Changes – Employer complete this section if applicable

❑ Salary change	New Salary: $_____ Per: O Hour Hours per week _____ O Week O Month O Year
❑ Division / Billing Group Change	New Division / Billing Group Number: Division / Billing Group Name:
❑ Class Code Change	New Class Code: Class name:
	New occupation:
❑ Terminate employee	Reason:

Section 3 – Employee / Family Changes – Employee complete this section if applicable (please use legal names only):

❑ Employee name change	❑ New last name: ❑New first name:
❑ Spouse name change	❑ New last name: ❑New first name:
❑ Address change	New address: (number, street, suite #)
	City Province Postal Code
❑ Add spouse	Last Name First Name
	Date of birth (mm/dd/yyyy) Gender: O Male O Female
	O Common-law – provide date of cohabitation (mm/dd/yyyy) O Married – provide date of marriage (mm/dd/yyyy)
❑ Remove spouse	Reason:
❑ Add child 1	Last Name First Name Gender: O Male O Female
	Date of birth (mm/dd/yyyy) ❑ Date of adoption (mm/dd/yyyy)
	Relationship to you: (Attach copy of court order if you are the legal guardian)
❑ Add child 2	Last Name First Name Gender: O Male O Female
	Date of birth (mm/dd/yyyy) ❑ Date of adoption (mm/dd/yyyy)
	Relationship to you: (Attach copy of court order if you are the legal guardian)
❑ Remove child	Last name First name Reason:
❑ Additional information	Provide information that may be necessary to explain the requested change.

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Section 4 – Coordination of Benefit information – Employee complete this section if applicable

This information is required to establish which plan is primary and which plan is secondary for your family's claims. If your spouse's plan has terminated, we will remove it from our profile so that your family's claims are not disrupted. If you want to apply for EHC and/or Dental after previously declining these benefits, or if you now want to decline EHC and/or Dental after previously enrolling for these benefits, complete the *Amendment to Coverage Status* form.

❑ Add	❑ EHC ○ Single ○ Family ❑ Dental ○ Single ○ Family	Insurance Company Policy Number Effective date (mm/dd/yyyy)
❑ Remove	Spouse's plan for ❑EHC ❑Dental terminated on (mm/dd/yyyy)	

Section 5 – Employee and Employer signatures

I hereby declare that all the information provided in this form is true, correct and complete to the best of my knowledge. I consent to the personal information provided above being retained, used and disclosed in accordance with ICBA Benefit Service Ltd.'s privacy policy, a copy of which is available at icbabenefits.ca.		
Employee Signature (required if Section 3 or 4 completed)		Date signed (mm/dd/yyyy)
Employer Legal Name	Email address	Phone number
Employer Signature (required if Section 2 completed)		Date signed (mm/dd/yyyy)

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

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