Les services à l'enfance
Grandir ensemble

## Plan C

# Change Form

Group Insurance Plan - Desjardins Insurance - Policy 440303

Name of employer: _____

Effective date of change: (year/month/day) _____

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### 1. Information about the employee

Last name, first name: _____ ID number: _____

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### 2. Reinstatement following approved leave

Refer to the "*Change of participating employer and reinstatement*" section of the Guidelines for additional information about the terms and conditions for reinstating an employee.

Participant's date of return to work: Year _____ Month _____ Day _____

Reason for reinstatement (e.g., leave without pay, etc.) _____

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### 3. Change of name of employee

From: _____ To: _____

Last name First name Last name First name

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### 4. Exemption of coverage

You can waive your health and dental coverage **if you are covered under your spouse's plan**.
**Quebec residents:** Please note that health coverage is mandatory for employees and their dependants for employees residing in Quebec unless they are covered under another plan.

I understand the terms and conditions of the group insurance plan offered by my employer, but I waive the following:

Health coverage: ❒ for myself and my dependants ❒ for my dependants

Dental coverage: ❒ for myself and my dependants ❒ for my dependants

Name of spouse's insurer: _____ Plan number: _____

Effective date of change: Year _____ Month _____ Day _____

If you lose your coverage under your spouse's plan, you have **sixty (60) days** to apply for protection. After that, you will have to provide proof of insurability acceptable to Desjardins Insurance to be covered. Once your membership is approved, limits will be applied to your dental coverage.

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### 5. Waiver of coverage – for dependants even if they are not covered under the spouse's plan

You can waive your health and dental coverage for your dependants even if they are not covered under another plan. Please note that if you want to add them at a later date, you will have to provide proof of insurability acceptable to the insurer (at your expense), and the insurer may deny the coverage.
**Quebec residents:** Please note that health coverage is mandatory for employees and their dependants for employees residing in Quebec unless they are covered under another plan.

I understand the terms and conditions of the group insurance plan offered by my employer, but I waive the following:

Health coverage: ❒ for my dependants

Dental coverage: ❒ for my dependants

Name of employee: _____ ID number: _____

## 6. Addition of group health and dental coverage

You can apply for group insurance if your spouse is no longer covered under the latter's employer group insurance plan. That change must be made within **sixty (60) days** after the date when the situation changed.

Effective date of loss of protection under the spouse's plan: Year_____ Month_____ Day_____

❒ Health care ❒ Dental care

## 7. Change in information about dependants

Fill out this section if you would like to add or remove a dependant or update information about a dependant.

Effective date of change: Year _____ Month _____ Day _____

Change to: ❒ Individual coverage ❒ Family coverage ❒ Life insurance only

Reason: ❒ Birth of a child ❒ Marriage ❒ Separation / Divorce

❒ Cohabitation Date of marriage/cohabitation Year _____ Month _____ Day _____

Other (provide details) _____

Information about the spouse: Add ❒ Change ❒ Remove ❒ _____
Last name First name

Date of birth (year/month/day) _____/_____/_____ Sex: M ❒ F ❒

What group insurance coverage is offered under your spouse's plan?

| | | | | |
|---|---|---|---|---|
| Health care: | Individual____ | Family____ | Waived_____ | None_____ |
| Dental care: | Individual____ | Family____ | Waived_____ | None_____ |

**If applicable, benefits payable under your plan will be coordinated with those paid under your spouse's plan.**

Information about the children

| Add | Change | Remove | | | Date of birth Year/month/day | Sex M / F | Student full-time Yes | Disability functional Yes |
|---|---|---|---|---|---|---|---|---|
| ❒ | ❒ | ❒ | _____ | _____ | _____ | _____ | ❒ | ❒ |
| | | | Last name | First name | | | | |
| ❒ | ❒ | ❒ | _____ | _____ | _____ | _____ | ❒ | ❒ |
| | | | Last name | First name | | | | |
| ❒ | ❒ | ❒ | _____ | _____ | _____ | _____ | ❒ | ❒ |
| | | | Last name | First name | | | | |
| ❒ | ❒ | ❒ | _____ | _____ | _____ | _____ | ❒ | ❒ |
| | | | Last name | First name | | | | |

## 8. Authorization and declaration

I declare that to the best of my knowledge, the information provided is true, accurate and complete.
I confirm that a photocopy or an electronic copy of this authorization is as valid as the original.

Signature of the employee: _____ Date: _____

Signature of the employer: _____ Date: _____