GROUPE FINACTION™

Solutions intégrées et **novatrices** en assurance collective

ADDRESS OR TYPE OF COVERAGE CHANGE FORM

SECTION 1 – GENERAL INFORMATION

Employer name (name of branch/division): _____ Identification N° : _____

Last name : _____ First name : _____

Civil status : ◯ Single ◯ Separated ◯ Married ◯ Common law *If common law indicate start date of cohabitation (MM/YYYY) :_____

SECTION 2 – COMPLETE THIS SECTION ONLY IF YOUR ADDRESS HAS CHANGED

Effective date of the new address (DD/MM/YYYY) : _____

Address : _____

Apartment : _____ City : _____ Province : _____ Postal code : _____

Home phone N° : _____-_____-_____ Email : _____

SECTION 3 – TYPE OF COVERAGE – COMPLETE THIS SECTION ONLY IF YOU WANT TO CHANGE YOUR COVERAGE

Health Insurance :

- ◯ Individual plan
- ◯ Family plan
- ◯ Single parent
- ◯ Exemption - Coverage with spouse. ***Proof of insurance required for exemption*** (send proof with current form)

Dental care Insurance :

- ◯ Individual plan
- ◯ Family plan
- ◯ Single parent
- ◯ Exemption - Coverage with spouse. ***Proof of insurance required for exemption*** (send proof with current form)

**Insurance proofs accepted* : One amongst the following : copy of the insurance card on which your name appears, screen shot from your spouse's insurer's portal where we can see your name as an insured person, insurance confirmation letter from your spouse's insurer (or employer) where your name is listed as an insured person*

Reason for change : _____

Effective date of the new coverage: (DD/MM/YYYY) _____

SECTION 4 – DEPENDENT'S INFORMATION (COMPLETE THIS SECTION ONLY IF YOU WANT TO ADD OR DELETE DEPENDENTS)

	Last name/First name	Specify if you **add** or **delete** this dependent	Gender (H/F)	Date of birth (DD/MM/YYYY)	Full time student
Spouse					
Children 1					◯ Yes ◯ No
Children 2					◯ Yes ◯ No
Children 3					◯ Yes ◯ No
Children 4					◯ Yes ◯ No
Children 5					◯ Yes ◯ No

SECTION 5 - SIGNATURE OF THE PARTICIPANT, AUTHORIZATION AND DÉCLARATION

I DECLARE THAT THE INFORMATION PROVIDED IS ACCURATE. I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY PAY THE PREMIUM REQUIRED THEREFORE THE PROTECTION THAT I HAVE CHOSEN. I HEREBY AUTHORIZE THE INSURER AND ITS SERVICE PROVIDERS TO COLLECT AND EXCHANGE MEDICAL INFORMATION ABOUT MYSELF, MY SPOUSE AND/OR MY CHILDREN WITH HEALTH CARE PROFESSIONALS, MEDICAL AND SOCIAL SERVICE INSTITUTIONS AND GOVERNMENT AGENCIES (SUBJECT TO APPLICABLE LAW). I FURTHER AUTHORIZE THE LATTER PARTIES TO TRANSMIT SUCH INFORMATION TO THE INSURER AND ITS SERVICE PROVIDERS WITH A VIEW TO ENABLE THE INSURER AND ITS SERVICE PROVIDERS TO REVIEW ANY CLAIMS MADE UNDER THE GROUP INSURANCE POLICY AND TO MAINTAIN INDIVIDUAL HEALTH RECORDS EXCLUSIVELY FOR PURPOSES OF ADMINISTRATION OF THE GROUP PLAN. IN THE EVENT OF MY DEATH, I EXPRESSLY AUTHORIZE MY BENEFICIARY, HEIR OR EXECUTOR TO PROVIDE THE INSURER AND ITS SERVICE PROVIDERS ALL INFORMATION AND/OR AUTHORIZATION REQUIRED TO ENABLE THE REVIEW OF CLAIMS AND THE COLLECTION OF SUPPORTING DOCUMENTATION.

_____ _____

Signature of the participant (mandatory) Date (DD/MM/YYYY)