Combined Employee Change Form

Please mail original completed form to BBD:

Western Canada
500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
Fax: 604.464.7997 Toll Free: 800.667.1336

Eastern Canada
107 – 6 Cataraqui Street, Kingston, ON K7K 1Z7
Fax: 613.530.3770 Toll Free: 888.272.0414

Name of Employer:

▶ *To use this form you must already be insured under your employer's plan.* ◀
▶ *For a new enrollment complete a Group Insurance Enrollment form.* ◀

▶ *PLEASE PRINT. Submit original form only — fax copies or photocopies cannot be accepted.* ◀

Employee Last Name **First Name** **Initial**

Partial Waiver: Complete this section if an employee is enrolled under another Extended Health or Dental plan and wants to waive coverage under your plan.

Employee Last Name First Name Initial

Are you covered under your Provincial Health Plan?
☐ Yes ☐ No

I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)

▶ For myself and my dependents.....☐ Extended Health Care ☐ Dental Care **OR** ▶ For my dependents only.....☐ Extended Health Care ☐ Dental Care

Name of Other Plan's Employer/Policyholder

Name of Insurance Company

Group Number Identity Number

Is this your spouse's group plan?
☐ Yes ☐ No
(if no, provide details)

Reinstatement of Waived Benefits: Complete this section if an employee is no longer eligible for coverage under another group plan and wants to be covered under your plan.

▶ I now wish to apply for my employer's Extended Health Care and/or Dental Care benefits which I previously waived: (specify requested benefits below):

For myself only ..... ☐ Extended Health Care ☐ Dental Care

For myself and my dependents ..... ☐ Extended Health Care ☐ Dental Care

☐ Other (specify reason for application)

_____

_____

_____

▶ Reason for This Application (check one and provide details)

☐ Termination of the Other Plan
Date of termination _____

☐ Separation or Divorce
Date of termination from the other plan _____

If you have children, are they still covered under the other plan? ☐ Yes ☐ No

If yes, please specify the details of the other plan:

Name of Other Plan's Policyholder/Employer:

_____

Name of Insurance Company

_____

Group Number _____ Identity Number _____

SEE REVERSE

Name of Employer:

Employee Last Name	First Name	Initial

Name Change: Complete this section if an employee changes his or her name (e.g. due to marriage)

FORMER Employee Last Name	First name	Initial
NEW Employee Last Name	First name	Initial

Reason for Name Change:

☐ Married (Complete a Dependent Status Change form) ☐ Other (specify) _____

Dependent Status Change: Complete this section if an employee adds a new dependent or wishes to terminate a dependent.

Employee Last Name | First Name | Initial

Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

Dep. No.	List Dependents Last Name	First Name	Initial	Sex M/F	Birth Date Month	Day	Year	Relationship to You	If child is over plan's age limit (e.g. 19 or 21), and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits.
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

Reason for Dependent Status Change (check one and provide details)

☐ Marriage (complete dependent information)
Date of marriage _____

☐ Common Law Spouse (complete dependent information)
Date of cohabitation _____

☐ Birth or Adoption of Child (complete dependent information)
If adoption, provide date _____

☐ Child(ren) of Common Law Spouse (must reside with you – complete dependent information)
Date of acquiring dependent(s) _____

☐ Separation
Date of separation _____
Is spouse still to be covered? ☐ Yes ☐ No
Are children still to be covered? ☐ Yes ☐ No
(if no, complete Partial Waiver section)

☐ Death of Dependent
Date of death _____
Dependent Name _____
Relationship _____

☐ Divorce
Date of divorce _____
Is former spouse still to be covered? ☐ Yes ☐ No
Are children still to be covered? ☐ Yes ☐ No
(if no, complete Partial Waiver section)

☐ Other (specify – include date of change)
_____
_____