AGA BENEFIT SOLUTIONS

NOTICE OF CHANGE IN COVERAGE

All changes in employee status must be submitted within 31 days from the date of the event, if not, proof of insurability may be requested by the insurer

ADMINISTRATIVE INFORMATION

Employer/Policyholder name			Group/Division No.
Employee's last name	First name		Certificate No.
Address (No. / Street / Apt.)			
City	Province	Postal code	Telephone

Quebec Residents ☞ Before completing this section, please refer to the « BILL 33 » document on reverse

REQUIRED COVERAGE AND INFORMATION ON SPOUSE AND/OR CHILDREN

Health care :	☐ Single ☐ Single parent ☐ Couple ☐ Family ☐ Opt-out – Reason: _____
Dental care:	☐ Single ☐ Single parent ☐ Couple ☐ Family ☐ Opt-out – Reason: _____
Dependent Life benefit: (if it is part of your plan)	Do you want to cover your dependent for Dependent Life benefit? ☐ Yes ☐ No (This benefit may be mandatory with some insurers if you have eligible spouse and/or children)

SPOUSE AND/OR CHILDREN IDENTIFICATION

The Dependent Life benefit coverage, if part of your plan, may be mandatory with some insurers if you have eligible spouse and/or children. You must indicate all information regarding your eligible spouse and/or children even if you choose a "Single" coverage or if you choose to "Opt-out".

	Last name	First name	Sex M	Sex F	Date of birth (YYYY - MM - DD)	If aged 21 or older, please specify		Are your spouse/children covered by another plan ? Health care Yes	Health care No	Dental care Yes	Dental care No
Spouse			☐	☐		Full-time student	Handicapped	☐	☐	☐	☐
Child 1			☐	☐		☐	☐	☐	☐	☐	☐
Child 2			☐	☐		☐	☐	☐	☐	☐	☐
Child 3			☐	☐		☐	☐	☐	☐	☐	☐
Child 4			☐	☐		☐	☐	☐	☐	☐	☐
Child 5			☐	☐		☐	☐	☐	☐	☐	☐
Child 6			☐	☐		☐	☐	☐	☐	☐	☐
Child 7			☐	☐		☐	☐	☐	☐	☐	☐

If you have answered « Yes » to the question: « Are your children covered by another plan? », please confirm details on the back of this page. This information is necessary to apply the rules for the coordination of benefits.

LIFE EVENTS :			
☐	Marriage/civil union	Date of marriage/civil union ➡	(YYYY - MM - DD)
☐	Common-law spouse	Date of start of cohabitation ➡	(YYYY - MM - DD)
☐	Separation/divorce	Date of separation/divorce ➡	(YYYY - MM - DD)
☐	Birth/adoption	Date of birth/adoption ➡	(YYYY - MM - DD)
☐	Adding a full-time student child	Name : _____ ➡	(YYYY - MM - DD)
☐	Decease	Name : _____ ➡	(YYYY - MM - DD)
☐	End of eligibility of a dependent	Name: _____ ➡	(YYYY - MM - DD)
☐	Coverage by the spousal/parent plan	Start date of coverage ➡	(YYYY - MM - DD)
☐	End of coverage by the spousal/parent plan	End date of coverage ➡	(YYYY - MM - DD)
☐	Involuntary end of spousal/parent coverage	End date of coverage ➡	(YYYY - MM - DD)
☐	Coverage by an educational institution plan	Start date of coverage ➡	(YYYY - MM - DD)
☐	Other : _____	Date of change ➡	(YYYY - MM - DD)

EMPLOYEE'S SIGNATURE

Employee's signature	Date

Children covered by another plan – Please provide the following details :

Indicate for which child the following applies – Child # : _____

Health care	**Dental care**
☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution: ☐ including drug coverage ☐ excluding drug coverage ***If the parents are separated, divorced or not living together :*** Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____	☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution: ***If the parents are separated, divorced or not living together :*** Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____

Indicate for which child the following applies – Child # : _____

Health care	**Dental care**
☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution: ☐ including drug coverage ☐ excluding drug coverage ***If the parents are separated, divorced or not living together :*** Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____	☐ Coverage by the plan of current spouse ☐ Coverage by the plan of the other parent ☐ Coverage by the plan of the spouse of the other parent ☐ Coverage by the plan of the other parent and the spouse of the other parent ☐ Coverage by the plan of an educational institution: ☐ including drug coverage ☐ excluding drug coverage ***If the parents are separated, divorced or not living together :*** Are you the sole custodial parent? ☐ **or** Does the other parent have sole custodial? ☐ **or** Do you have shared custody? ☐ If you share custody, please indicate other parent's date of birth : (YYYY/MM/DD) : _____

Initials : _____

QUEBEC RESIDENTS ONLY
BILL 33 - « DID YOU KNOW … »

- ✓ *On January 1st, 1997, Bill 33 (Quebec Universal Drug Plan) became effective for all Quebec residents.*
- ✓ *All Quebec residents under 65 years of age that have access to a group insurance plan, are obliged to join the group plan. If a person is covered by another group plan or if a person is covered by a spouse's group plan, proof of such coverage must be filed with your employer.*
- ✓ *On the group insurance application form with your employer, you are obliged to insure all eligible dependents, spouse and children, unless these dependents are already covered by another group plan.*
- ✓ *Your eligible dependents cannot be insured with R.A.M.Q. (Quebec Universal Drug Plan) if you are covered by your employer's group plan, with the exception of a spouse, aged 65 years and over.*
- ✓ *When filing your Quebec tax return, you will be asked if you have met the requirements according to this law.*

For further information, please do not hesitate to contact Customer Service at the following numbers :

Montreal area:	***514-935-5444***
Elsewhere in Quebec:	***1 800 363-6217***
Fax:	***514-935-1147***