SEVENTH-DAY ADVENTIST CHURCH IN CANADA

HEALTH BENEFITS PLAN

KING STREET EAST, OSHAWA, ON L1H 1H8
TELEPHONE: 1-800-263-7868

Benefit Change Request (*Employee*)

Employee	Effective Date of Change (dd/mm/yy)
Address	
Employer	

Change Request:

- ☐ Add Spouse/Dependent --- Reason for change: _____
- ☐ Address Change
- ☐ Name Change --- Reason for change: _____
- ☐ Remove Family Member - Name: --- Reason for change: _____

New Address:

Name Change to:

Spouse Information:

Last Name:	First Name:

Birthdate (dd/mm/yy)

Address

I request to add my spouse for dental and extended health benefits. ☐ Yes ☐ No	Does your spouse have any valid Canadian Provincial Health Card? ☐ Yes ☐ No

If your Spouse is unemployed / retired, he/she can participate in the Plan at no additional cost.
Is your Spouse employed? ☐ Yes ☐ No *Is your Spouse retired?* ☐ Yes ☐ No

If Spouse is employed, gross income must be less than $46,000.00 annually and a Statement of Income is required to participate in the plan at no additional cost. ***You must include a copy of your spouse's most recent Notice of Assessment from Canada Revenue Agency as a verification of your spouse's income.***

Please note: If health care coverage is available to your Spouse through their own employer, they may not opt out of that coverage.

If Spouse gross income is greater than $46,000.00 annually you may choose to purchase a spouse buy-in at the cost of $144.50 per month, ***for a minimum of 1 year,*** *which provides extended health and dental coverage for your spouse.*
Would you like to purchase a spousal buy-in? ☐ Yes ☐ No
Please note: If health care coverage is available to your Spouse through their own employer, they may not opt out of that coverage.

Dependent Information:

Last Name	First Name
Birthdate (dd/mm/yy)	Sex: ☐ Female ☐ Male
Address	
Is Dependent a student?	☐ Yes ☐ No

I certify the above information is true and correct and confirm I am authorized to act on behalf of my spouse and dependents when applying for coverage or for purposes of the ongoing administration of my health benefits plan.

Employee Signature_____Date_____

Please return the completed form to the address above or send by e-mail to healthbenefits@adventist.ca