



SEVENTH-DAY ADVENTIST CHURCH IN  
CANADA

**HEALTH BENEFITS PLAN**

1148 KING STREET EAST, OSHAWA, ON L1H 1H8  
TELEPHONE: 1-800-263-7868 OR 905-433-3964

**Benefit  
Change Request  
(Employee)**

Employee		Effective Date of Change (dd/mm/yy)
Address		
Employer		
<b>Change Request:</b>  <input type="checkbox"/> Add Spouse/Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Remove Family Member - Name:		
New Address:		
Name Change to:		
<b>Spouse Information:</b>		
Last Name:	First Name:	
Birthdate (dd/mm/yy)		
Address		
I request to add my spouse for dental and extended health benefits. <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your spouse have any valid Canadian Provincial Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

<b>Dependent Information:</b>	
Last Name	First Name
Birthdate (dd/mm/yy)	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Address	
Is Dependent a student?	<input type="checkbox"/> Yes <input type="checkbox"/> 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](mailto:healthbenefits@adventist.ca)