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	

Change Request:

- ☐ Add Spouse/Dependent
- ☐ Address Change
- ☐ Name Change
- ☐ Remove Family Member - Name:

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 Provincial Insurance? ☐ Yes ☐ 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 $35,000.00 annually and a Statement of Income is required to participate in the plan at no additional cost. Please attach proof of income with this request.

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 $35,000.00 annually you may choose to purchase a spouse buy-in at the cost of $261.00 per month 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