



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: <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:		
Spouse Information:		
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 Provincial Insurance? <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 \$40,000.00 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 \$40,000.00 annually you may choose to purchase a spouse buy-in at the cost of \$272.00 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: <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