

# ELCIC Group Services Inc.

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## CHANGE OF MARITAL STATUS

### Member Information

Member name:	<i>Last</i>	<i>First</i>	Member number:
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Please complete the following section only if your home address and/or phone number has changed:

Home Address:	<i>Street</i>	<i>City &amp; Province</i>	<i>Postal Code</i>
E-mail Address:	Home Telephone:		(      )

<b>Change in Marital Status:</b> (attach copies of supporting legal documents such as marriage certificate, separation agreement, death certificate etc.)	<b>From:</b> <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated	<input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> common-law	<b>To:</b> <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced	<input type="checkbox"/> widowed <input type="checkbox"/> common-law	<b>Date of Change</b> (d/m/y)

### Spouse / Dependent Information (See definitions listed below)

Relationship to Employee	Last Name	First Name	Gender (M/F)	Date of Birth (d/m/y)	S.I.N.
Spouse					

If there are any change in dependents please list below:

Child					Not Required
Child					Not Required
Child					Not Required
Child					Not Required

Does your spouse have extended health and/or dental benefits through his/her current employer that includes coverage for you and your dependents?

YES  NO

If "YES", you must select one of the following options:

- You may **WAIVE** your extended health and/or dental coverage. If at anytime your spouse loses his/her extended health and/or dental coverage, you must enroll for coverage of these benefits under your true family status.
- You may **CO-ORDINATE** your extended health and/or dental benefits with those of your spouse. Co-ordination of benefits allows for reimbursement of insured medical and dental expenses from both yours and your spouse's plans, up to a total of 100% of the actual expense incurred.

Spouse – The person to whom you are legally married; or a person continuously living with you in a role like that of a marriage partner for at least one year.

Dependent Child/ Children – Your natural or legally adopted child (dependent on you or your spouse for financial support), or a stepchild, who is: unmarried; under age 21, or under age 25 if a full-time student; not employed on a full-time basis; and not eligible for insurance as an employee under this or any other group benefit program.

### Authorization

A. I wish to **WAIVE** the following benefits:  Extended Health  Dental  
 (A letter from your spouse's employer confirming your coverage under his/her plans must be attached to this completed form.)

**OR**

B. I wish to **CO-ORDINATE** the following benefits with those of my spouse:  Extended Health  Dental

Effective Date of Spouse's Coverage: (d/m/y) \_\_\_\_\_

Spouse's Group/Plan #: \_\_\_\_\_ Spouse's Plan Member/Certificate #: \_\_\_\_\_

Member's signature \_\_\_\_\_

Date \_\_\_\_\_

*Day Month Year*