EMPLOYEE CHANGE REQUEST FORM

To be completed by the employer for any additional employees and/or dependents, terminated employees or removed dependents or to detail any changes to employee information.

Group Name: _____ Group No.: _____

Name (Last, First, Middle Initial)	**Cert. No.**	**Cover** SHIC	SHIC Plus	Prov Plan	Prem Health	**Type of Change** Add*,	Delete**	Amend	**Effective Date** dd/mm/yy	**Dependent's Full Name** ☐ Adding/Deleting Dependent only	**Relation*** ** Employee EE, Spouse SP or Child CH	**New Salary**	**For Ins. Co. Use**
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Other													

Administrator Signature: _____ Print Name: _____ Date: _____

* Must be accompanied by a fully-completed Enrolment Card ** Must be accompanied by the employee's Insurance ID card(s) *** If adding a working spouse, please name their employer