BRITCAY

# Health Insurance

## INFORMATION CHANGE REQUEST

### I EMPLOYEE'S DETAILS

Surname _____ First Name _____ Middle Initial(s) _____

Address _____

Contact Nos - Home _____ Work _____ Other _____

Group Name/No. _____ Certificate No. _____

Position/Job Title _____ Date of Birth (DD/MM/YY) _____

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

### II TYPE OF CHANGE REQUESTED (please tick all that apply)

1. ☐ Change coverage to: ☐ SHIC ☐ SHIC Plus ☐ Provident Plan ☐ Premier Health
   ☐ Individual ☐ Family ☐ Individual & Child ☐ Individual & Children
   ☐ Add a Dependent (fill in details in chart under 3.)

   If adding a spouse, please attach a copy of the Marriage Certificate and give date of marriage - (DD/MM/YY) _____

   If adding an adopted child, please attach a copy of the Adoption Certificate and give date of adoption - (DD/MM/YY) _____

   If adding a child with a different last name, please include a copy of their Birth Certificate.

2. ☐ Remove a Dependent (fill in details in chart below)

   If removing a family member, give reason and effective date: _____

| Added/Removed Dependent(s) (Surname, First Name, Initials) | Date of Birth (DD/MM/YY) | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

3. ☐ Change address to address noted in Section I.
4. ☐ Change name from _____ to name noted above.

   Please attach supporting documentation proving name change.

### III SIGNATURES

Signature of Employee _____ Date _____

Signature of Employer _____ Date _____

| FOR OFFICE USE | Service Code: | Effective Date of Coverage: |
|---|---|---|
| | | |

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