

## PERSONAL INFORMATION CHANGE FORM



## TO BE COMPLETED BY EMPLOYEE

(Complete only those areas requiring a change. **Please print and use capital letters**. *Additional forms may be required, depending on the personal information change*.

Date of Birth (mm/dd/yyyy)   Gender   Effective Date (mm/dd/yyyy)	Last Name			First Nam	First Name			Middle Initial SIN					
New Address													
New Address	□ Nam	o Chango											
New Address   Street and no.   City/town   Province   Postal code					Ī	To (Last name first name and initial)							
New Telephone Number	Trom (Last name, mst name and midal)				To (East name, met name and military								
New Telephone Number	☐ New	Address											
Area code    Number	Street and no.				City/town F			Province Postal code			de		
Area code    Number													
Change in Marital Status Please complete if you are adding or removing your spouse.  Please Note: Your spouse will be added to those benefits that are currently at family status. If you would like to change your status or apply for Optional Life and/or Critical Illness for this spouse please complete a Benefit Change Form.  Last Name of Spouse Middle Initial Marital (mm/dd/yyyy)  Gender Effective Date (mm/dd/yyyy)  Action*  ("O - Delete, A - Add, C - Change)  Widowed - (mm/dd/yyyy)  Separated (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  New/Change Children Information  Action*  Last name First name Initial Gender Gender (mm/dd/yyyy)  Separated (mm/dd/yyyy)  New/Change Children Information  Action*  Last name First name Initial Gender Gender (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Please indicate any other dependent children on an additional application form. If the dependent child is between ages 21 and 26, you must provide proof that your child is attending an accredited educational institution on a full-time basis. If the child is disabled, please see your benefit administrator for the appropriate forms.  DECLARATION AND AUTHORIZATION  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Separated (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Separated (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Separated (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Separated (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Divorced (mm/dd/yyyy)  Separated (mm/dd/yyyy)  Divorced (mm/dd/yyyy)	☐ New	Telephone Number	<u> </u>										
Please Note: Your spouse will be added to those benefits that are currently at family status. If you would like to change your status or apply for populoral Life and/or Oritical Illiness for this spouse please complete a Benefit Change Ferm.  Last Name of Spouse   Middle Initial	Area coo	le	Number										
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Date of Birth (mm/dd/yyyy)   Divorced (mm/dd/yyyy)										our s	status or	apply for	
Date of Birth (mm/dd/yyyy)   Gender   Effective Date (mm/dd/yyyy)	Optional Life and/or Critical Illness for this spouse please complete a Benefit Change Form.												
Action* ("D - Delete, A - Add, C - Change)    Married (mm/dd/yyyy)   Separated (mm/dd/yyyy)   Divorced (mm/dd/yyyy)	Last Name of Spouse			irst Name of Spouse			Middle Initial						
Action* (**)D - Delete, A - Add, C - Change)    Married (mm/dd/yyyy)   Separated (mm/dd/yyyy)   Divorced (mm/dd/yyyy)				Canadan Effective									
New/Change Children Information	Date of Birth (mm/dd/yyyy)			Gender	ender Enective Date (m			//dd/yyyy)					
New/Change Children Information	(*D – Delete, A – Add, C – Change)			d/yyyy)		Common-law spouse – d			date of cohabitation (mm/dd/yyyy)				
Action*  Last name  First name  Initial Gender  MM DD YYYY  Status**  Dependent Status**  O2 -  03 -  04 -  "** CH - Child, E - Student (college/university), S - Disabled Please indicate any other dependent children on an additional application form. If the dependent child is between ages 21 and 26, you must provide proof that your child is attending an accredited educational institution on a full-time basis. If the child is disabled, please see your benefit administrator for the appropriate forms.  DECLARATION AND AUTHORIZATION  I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, administering changes to benefits coverage, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of determining their eligibility for benefits and my of the uses set out above.  I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting. I authorize my employer to deduct from my earnings required contributions for coverage under these plans.  Date (MM/DD/YYYYY)  Signature of Employee  To BE COMPLETED BY EMPLOYER ONLY  Division name (include site/location/zone)  Employee name  Payroll number  Cert number  Signature of Authorized Benefits Administrator  Sig			´	n/dd/yyyy	/)	Separate		ed (mm/dd/yyyy)			Divorced (mm/dd/yyyy)		
Last name   First name   Initial   Gender   Date of birth   Dependent   Status**													
Action* Last name First name Initial Gender MM DD YYYYY status**    02 -   03 -   04 -     04 -       05 -       05 -       05 -       05 -       05 -       05 -       05 -       05 -         05 -       05 -       05 -         05 -	☐ New	/Change Children Ir	nformation										
02 -   03 -   04 -     04 -     05 -   04 -     06 -   07 -   07 -   08 -   08 -   08 -   09 -   0	Action*	Last name					Initial	Gender				•	
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Employer - Please upload to your facility folder on our secure SharePoint site. Please do not also forward the original to Health Association Nova Scotia – Keep the original for your records.