



**COST PLUS
ENROLMENT / CHANGE FORM**

Employer / Plan Section (to be completed by the plan administrator)

Company Name: _____ Division: _____ Policy No: _____

- Enrol Employee (Plan effective date: _____) Add Dependant: (Effective date: _____)
- Reinstate Employee (Plan effective date: _____) Change Address
- Terminate Employee (Termination date : _____) Remove Dependant (Term. date: _____)

Employee/ Participant Details (to be completed by the employee)

Last Name: _____ First Name: _____ M/F: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (mm/dd/yyyy): _____ Daytime Phone Number: _____

Coverage Status: Single: _____ Couple: _____ Family: _____ Waived: _____

Dependant Details (to be completed by the employee)

(mm/dd/yyyy)

Spouse: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 1: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 2: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 3: Last Name: _____ First: _____ Sex: _____ DOB: _____

Child 4: Last Name: _____ First: _____ Sex: _____ DOB: _____

Please indicate the name of any disabled dependants: _____

Please indicate below, if dependants are full time students and over age 21.

Attach the registration letter, which confirms full-time enrolment.

Name of Over Age Student	College/University Attended	Enrolled From	Enrolled To
_____	_____	_____	_____
_____	_____	_____	_____

Signature (to be completed by the employee)

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

I understand that in the event of termination of employment or voluntary termination of plan participation I will not receive a refund of any unused Health Spending Account contributions.

Employee / Subscriber Signature: _____

Employee / Subscriber Name (Please Print): _____

Date: _____

For Plan Administrator Use

- Keep the original form for your records.