gpm group benefits

250-2 Place Laval, Laval, QC H7N 5N6
T 450.667.7737 | info@gpm.ca | **gpm.ca**

EMPLOYEE CHANGE FORM (B)

Group No. **GPM User ID**

PARTICIPANT'S STATEMENT

Group Name

Participant´s Family Name(s) Participant's Given Name(s)

Phone No. Participant's Email Address

TO BE COMPLETED BY THE EMPLOYEE

Effective Date of Change (d/m/y)

Please **PRINT** and **PROMPTLY RETURN** this form to your employer to confirm the changes.

I want the following coverage: **EXTENDED HEALTH CARE**: ☐ Individual ☐ Couple ☐ Single-Parent ☐ Family ☐ Exemption*

I want the following coverage: **DENTAL CARE** (if applicable): ☐ Individual ☐ Couple ☐ Single-Parent ☐ Family ☐ Exemption*

* Participation is mandatory for you and your eligible dependents in accordance with the **Eligibility clause in your Benefits Booklet**. Regardless of your province of residence, you may be exempted from participation in the Extended Health Care and Dental Care coverage if you or your dependents are covered by similar benefits under another group insurance plan.

Reason for the Change Please tick a reason and fill in the requested information.

☐ Marriage
Indicate date of marriage
Date (d/m/y)

☐ Common Law Partner or Spouse (Eligibility for common law spouses begins after 12 months of continuous cohabitation). Indicate the effective date of cohabitation:
Date (d/m/y)

Is your spouse covered under another group plan? No ☐ If yes: Health Care: Ind ☐ Fam ☐ Dental Care: Ind ☐ Fam ☐

☐ End of Spousal Insurance
Date spousal insurance terminated
Date (d/m/y)

☐ Birth of a child

☐ If you have another reason for updating your file, please specify here:

☐ Separation/Divorce
Date (d/m/y)

Do you have dependent children under the age 26 living in Canada?
☐ No ☐ Yes*

Are your dependent children covered under another group plan?
Health Care: ☐ No ☐ Yes Dental Care: ☐ No ☐ Yes

* If checked yes, a proof of status will be required if the child is considered disabled or is a full-time student, as defined in your contract.

I Wish for the Following Person(s) to be Included in the Coverage:

	Family Name(s)	Given Name(s)	Gender	Date of Birth (d/m/yyyy)	Status
SPOUSE			○ F ○ M		○ Add ○ Terminated
CHILD 1			○ F ○ M		○ Add ○ Terminated
CHILD 2			○ F ○ M		○ Add ○ Terminated
CHILD 3			○ F ○ M		○ Add ○ Terminated
CHILD 4			○ F ○ M		○ Add ○ Terminated

DECLARATION AND AUTHORIZATION

I understand that my coverage and that of my dependents, under the group insurance plan are conditional upon my dependents and I maintaining full coverage under the Public Health Care Insurance Plan in our province of residence. I certify that the above information is accurate and true. I understand that false, incomplete or inaccurate information may result in the rejection of any claim, or even the termination of part or all of my coverage through the Group Plan. I authorize GPM, its agents, representatives and service providers to collect, use, share, retain and disclose the information collected on this form and any information relating to my enrolment form regarding my dependents or myself, for the purposes of management, selection, verification or claims processing. I authorize my employer to deduct from my salary any contributions, if necessary, relating to my coverage through the group plan.

PARTICIPANT'S SIGNATURE **EMPLOYER'S SIGNATURE** Date (d/m/yyyy)