

Use this form to (indicate changes being made):

- Change Employee Information (name, address, telephone, email or marital status)
- Add, Delete or Change Dependent Information

Note: Changes in marital or dependent status that affect your benefit level require inclusion of "Employer Change Employee Benefit Level and Classification" form which is completed by your Employer.

EMPLOYEE INFORMATION

Name _____ <small>First Name Initial Last Name</small>	Employer _____
Address _____	SIN _____
City or Town _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Province _____ Postal Code _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law
Telephone: Res. _____ Cell. _____	Reason for change: _____
Email Address _____	Effective date of change (M/D/Y) _____

DEPENDENT INFORMATION

Dependent means: (a) a person co-habiting with the Employee who is either legally married to the Employee; or living with the Employee, and who is publicly represented as the Employee's spouse; (b) an unmarried Child under 21; (c) an unmarried Child who is registered and attending as a full-time Student at an institute of higher learning, and who is under age 25; (d) an unmarried Child who is incapable of supporting himself because of a mental or physical handicap. Child means, a child of the Employee or his spouse, or common law spouse, and shall include a stepchild, adopted child, or foster child.

A = Add D = Delete C = Change	Relation	Name of Dependent (First Name, Initial, Last Name)	Sex	Date of Birth (Month, Day, Year)	Full Time Student	Disabled Dependent
	Spouse		<input type="checkbox"/> M <input type="checkbox"/> F		N/A	N/A
	Child		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYEE AUTHORIZATION

I have read and understood the contents of this form. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents for the purposes of determining their eligibility for benefits. I authorize payroll deductions by my employer if required and consent to the use by MediDirect® Inc. of my Social Insurance Number for the purpose of benefits administration. I give consent on the understanding that all information provided by me will be used solely for purposes of administration and management of my benefit plan, as well as enable MediDirect® Inc. to keep me better informed of all benefits that are or may become available.

Signature _____ Date _____

PRIVACY STATEMENT

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