Alberta Health Services

Benefits Change Request - UNA

Complete request and submit by *(choose one)*

Fax: Benefits Administration at 1.888.908.0330

Email: benefitsadmin.ahs@ahs.ca

Employee Number	Last Name	First Name

Type of Request Change ☐ Dependent information ☐ Coverage ☐ Both

Change In Dependent Information *(spouse, common-law partner)*

☐ Add ☐ Delete ☐ Correction	Spouse Last Name	First Name	Initial
	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male ☐ X* **X = Agender, Gender Fluid, Gender Queer, Intersex, Non-Binary, Two-Spirit, and Not Listed*	
☐ Add ☐ Delete ☐ Correction	Common-law Last Name	First Name	Initial
	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male ☐ X* **X = Agender, Gender Fluid, Gender Queer, Intersex, Non-Binary, Two-Spirit, and Not Listed*	

Reason for Change in spouse/common-law

☐ Marriage Date *(dd-Mon-yyyy)* _____

☐ Common-law Co-habitation *(if checked, complete)* →
Start Date _____

☐ Divorce/Separation Date _____

☐ Death Date _____

☐ Correction of Information

☐ Date Spouse entered Canada
Date of Entry _____

I hereby declare that the date of cohabitation provided is true and that I have cohabitated with _____ *(spouse name)* on a continuous basis for twelve (12) consecutive months and represented him/her as my spouse.

Signature	Date *(dd-Mon-yyyy)*

The collection of your personal information on this form is legally authorized by section 33(c) of the Freedom of Information and Protection of Privacy Act (Alberta). Your information will only be used and disclosed as necessary for your organization's human resources program including managing and administering your employment relationship with the organization.

If you have questions or concerns about this collection of your personal information as provided on this form, please contact an advisor at HR Shared Services by phone 1-877-511-4455, via the ServiceHub https://albertahealthservices.service-now.com/esc, or send your questions by mail to the attention of HR Shared Services, 10301 Southport Lane SW, Calgary, Alberta, T2W 1S7.

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Change In Dependent Information *(children)*

Codes for unmarried dependent children

A = An unmarried, fully dependent child less than the dependent age as specified in the Employee Benefit booklet.

B = An unmarried child over the dependent age but under the maximum age specified in the booklet. This dependent must be attending an accredited educational institution on a full-time basis. An annual Dependency Declaration is required for each school year. Apprenticeship is not applicable.

C = An unmarried child, over the dependent age as specified in the Employee Benefits Booklet, but fully dependent on me due to mental or physical disability.

☐ Add ☐ Delete ☐ Correction	Child 1 Last Name	First Name	Initial	Code
	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male ☐ X* **X = Agender, Gender Fluid, Gender Queer, Intersex, Non-Binary, Two-Spirit, and Not Listed*		
☐ Add ☐ Delete ☐ Correction	Child 2 Last Name	First Name	Initial	Code
	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male ☐ X* **X = Agender, Gender Fluid, Gender Queer, Intersex, Non-Binary, Two-Spirit, and Not Listed*		
☐ Add ☐ Delete ☐ Correction	Child 3 Last Name	First Name	Initial	Code
	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male ☐ X* **X = Agender, Gender Fluid, Gender Queer, Intersex, Non-Binary, Two-Spirit, and Not Listed*		
☐ Add ☐ Delete ☐ Correction	Child 4 Last Name	First Name	Initial	Code
	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male ☐ X* **X = Agender, Gender Fluid, Gender Queer, Intersex, Non-Binary, Two-Spirit, and Not Listed*		

Reason for Change in dependent child(ren)

☐ Birth Date *(dd-Mon-yyyy)* _____

☐ Child(ren) of Spouse/common-law

☐ Adoption Date *(dd-Mon-yyyy)* _____ Attach proof of Adoption

☐ Overage Dependent *(please see the Over-Age Dependent Declaration)*

☐ Legal Guardianship Date *(dd-Mon-yyyy)* _____ Attach proof of Legal Guardianship

☐ Death Date *(dd-Mon-yyyy)* _____

☐ Other _____

☐ Correction of Information

Change in Medical Coverage

☐ **Supplemental Health and Dental**

I understand that if benefits have been cancelled, I will not be able to re-enroll for these benefits at a later date unless application occurs within 31 days of termination of spousal/other group coverage. Please note late applicant rules may apply.

☐ **Add** the following benefits as coverage has been terminated under a spouse/other group plan.
- ☐ Supplemental Health
- ☐ Dental

☐ **Cancel** the following benefits as coverage has been added under a spousal/other group plan. Please provide proof of coverage elsewhere.
- ☐ Supplemental Health — Cancellation Date *(dd-Mon-yyyy)* _____
- ☐ Dental — Group Number _____

Insurance Company Name _____

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Change in Life and Accidental Death and Dismemberment Coverage

(Medical evidence may be required for these options)

☐ **Additional Basic Life Insurance and Additional Basic Accidental Death & Dismemberment**

This is an extra one times your salary.

☐ Request to add this benefit *(must take both Life and Accidental Death & Dismemberment)*

☐ Cancel this benefit Cancellation date *(dd-Mon-yyyy)* _____

☐ **Optional Employee Life** *(in units of $10,000 to a maximum of $250,000)*

☐ Request to **Increase** my coverage from $ _____ to $ _____

☐ Request to **Decrease** my coverage from $ _____ to $ _____

☐ Cancel this benefit Cancellation date *(dd-Mon-yyyy)* _____

☐ **Optional Spousal Life** *(in units of $10,000 to a maximum of $250,000)*

Spouse Date of Birth *(dd-Mon-yyyy)* _____

☐ Request to **Increase** my coverage from $ _____ to $ _____

☐ Request to **Decrease** my coverage from $ _____ to $ _____

☐ Cancel this benefit Cancellation date *(dd-Mon-yyyy)* _____

☐ **Optional Child Life** *(in units of $5,000 to a maximum of $25,000)*

☐ Request to **Increase** my coverage from $ _____ per child to $ _____

☐ Request to **Decrease** my coverage from $ _____ per child to $ _____

☐ Cancel this benefit Cancellation date *(dd-Mon-yyyy)* _____

☐ **Optional Dependent Life** *($25,000 for spouse/common-law and $10,000 for each child)*

☐ Request to add this benefit Effective date *(dd-Mon-yyyy)* _____ *(date 1st dependent eligible)*

☐ Cancel this benefit Cancellation date *(dd-Mon-yyyy)* _____

☐ **Optional Accidental Death & Dismemberment** *(in units of $25,000 to a maximum of $500,000)*

(If you choose family, your spouse/common-law is insured at 50% of your coverage and each child is insured at 25% to a maximum of $50,000 per child.)

☐ Request to add this benefit *(choose one)*

☐ Single AD&D ☐ Family AD&D

☐ Request to change my AD&D insurance status *(choose one)*

☐ Single to Family ☐ Family to Single

☐ Request to **Increase** my coverage from $ _____ to $ _____

☐ Request to **Decrease** my coverage from $ _____ to $ _____

☐ Cancel this benefit Cancellation date *(dd-Mon-yyyy)* _____

Employee Signature	Date *(dd-Mon-yyyy)*