OUR FLEX BENEFITS PROGRAM

Going Places Together.

RED RIVER COLLEGE

Notice of Change

canada life

Policy No. 57353 – Flex Health, Dental & Health Spending Account
Policy No. 160733 – Global Medical Assistance

Must Submit within 60 days of the Life Event
Please submit completed form to Human Resource Services

NAME: _____ **ID #:** _____ **HOME TELEPHONE: (_____)_____**

DEPARTMENT: _____

1. ☐ CHANGE OF NAME			
Surname:	Given Name and Middle Initial(s):		
2. ☐ CHANGE OF ADDRESS AND/OR HOME TELEPHONE			
Address:	City:		
Province:	Postal Code:	Home Telephone: ( )	
3. ☐ ADD SPOUSE			
Surname (if different from Employee Surname):	Given Name and Middle Initial(s):	Birth Date (*month/day/year*):	Gender: ☐ *Male* ☐ *Female*
☐ *Legally Married* ☐ *Common Law*	If common law, please provide commencement date of cohabitation (*month/day/year*):		
4. ☐ DELETE SPOUSE			
Surname (if different from Employee Surname):	Given Name and Middle Initial(s):	Reason:	Effective Date (month/day/year):

5. ☐ ADD UNMARRIED DEPENDENT CHILDREN (Please use back of this page if additional space required.)

Surname (if different from Employee Surname)	Given Name and Middle Initial(s)	Gender *Male*	Gender *Female*	Birth Date (*month/day/year*)	Full-time Student *Yes*	Full-time Student *No*	Disabled prior age 22 *Yes*	Disabled prior age 22 *No*
		☐	☐		☐	☐	☐	☐
		☐	☐		☐	☐	☐	☐
		☐	☐		☐	☐	☐	☐

6. ☐ DELETE DEPENDENT CHILDREN			
Surname (if different from Employee Surname):	Given Name and Middle Initial(s):	Reason:	Effective Date (month/day/year):
7. ☐ CHANGE IN SPOUSE'S COVERAGE – satisfactory proof must be provided in the event of a loss or gain of coverage:			
Loss of Coverage	☐	Effective Date (month/day/year):	
Gain of Coverage	☐	Effective Date (month/day/year):	
8. ☐ OTHER CHANGES			
Specify: _____			

***Flex Option* –** you can select a different Flex Option due to a Life Event if submitted **within 60 days** of the event. Complete and submit the Flex Enrolment Form along with this Change Form to Human Resources, C410.

***Claims Note* –** If you select a different Flex Option**, y**ou have 31 days from the effective date of your new Option to claim against your previous Flex Option Health Care Spending Account for claims incurred prior to the effective date.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this application is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee Signature: _____

Date *(month/day/year)*:_____

OFFICE USE ONLY:

Changed on GroupNet by:	Date Entered (*month/day/year*):