



# EMPLOYEE CHANGE

**Mailing Address:**

PO Box 7000, Vancouver, BC V6B 4E1

**Street Address:**

4250 Canada Way, Burnaby, BC

**Fax:** 604 419-2149

for PBC office use only

Group Number(s) of Plans to be Changed

Dental Care

Extended Health

BC Life

Surname	First Name	Middle Initial	ID Number (e.g. S.I.N.)
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Name of Company/Organization	Effective Date of Employee Change (mm/dd/yy)
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**Employee Change: Check all relevant boxes and provide requested information**

**Name Change** Employee's former name \_\_\_\_\_

**Address Change** New address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**Salary Change** New salary \_\_\_\_\_  Hour  Week  Bi- Weekly  Month  Year Number of hours worked per week \_\_\_\_\_

**Class/Payroll Change** New class \_\_\_\_\_ New department number \_\_\_\_\_ New employee number \_\_\_\_\_  
Occupation (required for class change) \_\_\_\_\_

**Terminate Employee** Date(mm/dd/yy) \_\_\_\_\_ Reason for termination \_\_\_\_\_

**Transfer Employee** Terminate from group number \_\_\_\_\_ Add to group number \_\_\_\_\_ Reason for transfer \_\_\_\_\_

**Dependent Change: Check all relevant boxes and provide requested information**

**Add**  **Change**  **Terminate** the **Dependent(s)** listed below:

If adding a spouse:  Date of marriage \_\_\_\_\_ (mm/dd/yy)  Date of cohabitation \_\_\_\_\_ (mm/dd/yy)

If any of your dependents were covered under another plan within the past 6 months, indicate the following:

Insurance company \_\_\_\_\_ Benefits  EHC  Dental

Group/Policy number(s) \_\_\_\_\_ ID number \_\_\_\_\_ Termination date (mm/dd/yy) \_\_\_\_\_

Dep. No	Surname* (* not required if same as yours)	First Name	Middle Initial	Birth Date (mm/dd/yy)	Sex	Termination Date	**See instructions below for required information
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		

**\*\*IN SPACE PROVIDED ABOVE:**

1) If you are adding:

- a dependent - give relationship to employee (If you are adding a legal ward, attach copy of court document.)
- student over plan age limit (19 or 21), give name of school
- handicapped child - give nature of disability
- adopted child - give date of adoption

2) If you are terminating dependent(s) - give reason.

3) If you are changing dependent's name - give former name

I hereby declare that all the information provided in this application is true and complete. I consent to the personal information provided above being retained, used and disclosed in accordance with Pacific Blue Cross/BC Life's privacy policy.

Note: A copy of the Privacy Policy is contained in your benefits booklet. It is also available on our Web site at [www.pac.bluecross.ca](http://www.pac.bluecross.ca) or from your employer.

**X** \_\_\_\_\_  
Signature of employee Date(mm/dd/yy)

**X** \_\_\_\_\_  
Signature of employer Date(mm/dd/yy)