CLEAR FORM

HEB Manitoba Use Only

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Healthcare Plan (PARIM)
Change Form

Please complete this form to change your personal information, family information or if you have acquired or lost alternate group healthcare coverage. Please complete all applicable sections and return the form to your employer representative.

Section 1: Employee Information Required

Employee Name: _____ (Last name) _____ (First name) _____ (Middle initial)

Mailing Address: _____ _____ (City) _____ (Province) _____ (Postal code)

Birth Date: _____ (DD) | _____ (MMM) | _____ (YYYY) ❑ Male ❑ Female

Employee SIN: _____ (For identification purposes) HEB Unique #: _____ (To be completed by HEB Manitoba)

Section 2: Employment Information To be completed by employer representative

Employer Name: Shared Health - PARIM Employer Number: 272

Employee ID: _____ Employment Date: _____ (DD) | _____ (MMM) | _____ (YYYY)

❑ **Employee is on an unpaid Leave of Absence (required)**

Section 3: Type of Change

Please select all changes that apply and complete the required section(s).

❑ Address change (Section A)
❑ Name change (Section B)
❑ Marital status/dependant information change (Section C)
❑ Acquire/loss of alternate group plan(s) (Section F)

Note: If you are adding a spouse/common-law partner and/or adding or deleting dependant children, you must also complete the Eligible Family Member section (Section D). If this change results in a change to your coverage level (ie. single or family) you must also complete Section E.

A. Change in Address

Former Mailing Address: _____ _____ (City) _____ (Province) _____ (Postal code)

Date of Change: _____ (DD) | _____ (MMM) | _____ (YYYY)

B. Change in Name

Former Name: _____ (Last name) _____ (First name) _____ (Middle initial)

Date of Change: _____ (DD) | _____ (MMM) | _____ (YYYY)

C. Change in Marital Status/Dependant Information

Please select all changes that apply and complete the required section(s)

Reason for change:
❑ Married (Section D and E)
❑ Common-law relationship (Section D and E)
❑ Separated/end of common-law relationship (Section D and E)
❑ Death of spouse/ common-law partner (Section D and E)
❑ Change in dependant information (Section D and E)

Date of Change: _____ (DD) | _____ (MMM) | _____ (YYYY)

D. Eligible Family Member Information

Spouse/Common-law Information ❑ Add ❑ Remove

Your spouse is defined as the person who is legally married to you. In the case of separation, the former spouse is no longer eligible for coverage. You must declare your spouse within 60 days of the date of marriage, otherwise restrictions will apply. Your common-law partner is defined as the person who has continuously resided with you for at least one full year, and whom you have represented as your conjugal partner. You must declare your common-law partner within 60 days of the date you **begin** living together (Date of Cohabitation), otherwise restrictions will apply. You are required to change your coverage from single to family, although he or she will not be eligible for coverage until you have lived together for one year. The date of coverage for your common-law partner will be the first of the month following the one-year anniversary of cohabitation. (Note: Unless you have other eligible family members, you will pay premiums for single coverage until your partner becomes eligible for coverage).

Name: _____ (Last name) _____ (First name) _____ (Middle initial) ❑ Male ❑ Female ❑ Does not reside in Canada

Birth Date: _____ (DD) | _____ (MMM) | _____ (YYYY) Date of Marriage: _____ (DD) | _____ (MMM) | _____ (YYYY) Date of Cohabitation: _____ (DD) | _____ (MMM) | _____ (YYYY)

Dependant Information

Last Name	First Name	Initial	Disabled	Male	Female	Date of Birth DD | MMM | YYYY	Add	Remove	Does Not Reside in Canada
			❑	❑	❑	| |	❑	❑	❑
			❑	❑	❑	| |	❑	❑	❑
			❑	❑	❑	| |	❑	❑	❑
			❑	❑	❑	| |	❑	❑	❑
			❑	❑	❑	| |	❑	❑	❑

E. Change in Coverage

❑ No change required ❑ Change required (please select the change that applies)

Changes to coverage must be made within 60 days of the event. e.g., marriage, separation, start or end of a common-law relationship, death, birth, adoption (legal documentation required), or if you have acquired or lost alternate group coverage. Changes to coverage made after 60 days of the event, will result in coverage restrictions. You must enrol in family coverage if you have a spouse/common-law partner and/or dependant children. Employees who have permanently opted-out of the Healthcare Plan are not eligible to join this Plan unless they terminate from their current position and are hired with a participating employer after a break of 31 days.

From: ❑ Single Healthcare coverage ❑ Family Healthcare coverage ❑ Waived Healthcare due to coverage under an alternate group plan (Section F)

To: ❑ Single Healthcare coverage ❑ Family Healthcare coverage ❑ Waived Healthcare due to coverage under an alternate group plan (Section F)

F. Acquired/Lost Coverage Under Alternate Group Plan(s)

Please select all changes that apply and complete the required section(s).

❑ I have acquired alternate group healthcare coverage and am waiving participation in the HEB Manitoba Healthcare Plan, which includes the HSA (Section E)

❑ I have lost my coverage under an alternate group healthcare plan and want to enrol in the HEB Manitoba Healthcare Plan, which includes the HSA (Section D and E)

You must notify HEB Manitoba within 60 days of acquiring or losing coverage under an alternate group plan in order to waive coverage or join the HEB Manitoba Healthcare Plan without restrictions. You must provide the name of the group healthcare coverage provider and plan number below.

Alternate Healthcare Coverage Provider: _____ Plan Number: _____

Effective Date of Acquiring Alternate Coverage: _____ | _____ | _____ (DD | MMM | YYYY) Effective Date of Loss of Alternate Coverage: _____ | _____ | _____ (DD | MMM | YYYY)

Section 4: Employee Authorization and Signature Required

I hereby acknowledge I have read and understand the terms and conditions of the Plans as outlined in the Healthcare Plan/Healthcare Spending Account brochure, and confirm the option(s) chosen above. Furthermore, I hereby authorize the administrators of the HEB Manitoba, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the purpose of administering the Plans. This includes enrolling members, appointing beneficiaries, determining my eligibility and entitlement, if any, to benefits, and processing my benefits.

❑ **I certify that I have declared my true family status (required)**

Employee Signature: _____ Date Signed: _____ | _____ | _____ (DD | MMM | YYYY)

Section 5: Employer Authorization and Signature Required

I am aware this employee is changing their HEB Manitoba Healthcare Plan information and I confirm that the appropriate adjustments to their premium deductions, if applicable, will be made.

Employer Representative Signature: _____ Date Signed: _____ | _____ | _____ (DD | MMM | YYYY)

Form Return:

Please submit completed form to the representative in your facility/RHA responsible for benefits, e.g., the Human Resources or Payroll Department. Your employer representative will submit your form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg, MB R3C 4L5.