Lewer Canada

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# Employer Change Form

**PLEASE COMPLETE NEATLY, SIGN SECTION ELEVEN, AND RETURN THE ORIGINAL BACK TO LEWER CANADA.** For more information please contact us by phone or email.

## Section One – Tell Us About Who You Are

| Company Name | |
|---|---|
| | |
| Contact Name | Phone Number |
| | |
| Email Address | Policy Number |
| | |

## Section Two – Tell Us What You Want To Do

☐ **Terminate an Employee** (Complete Section 3)

☐ **Request to Waive Waiting Period** (Complete Section 4)

☐ **Change / Update Salary** (Complete Section 5)

☐ **Change / Correct Occupation, Division or Class** (Complete Section 6)

☐ **Change / Correct Plan Administrator** (Complete Section 7)

☐ **Change / Correct Company Contact / Address Information** (Complete Section 8)

☐ **Cohabitation Declaration** (Complete Section 9)

☐ **Change Coverage Status – Waive, Change to Single, Change to Family coverage** (Section 10)

* Complete Authorization for all changes (Section 11)

## Section Three – Terminate an Employee

| Name of Employee |
|---|
| |
| Date Last Worked |
| Month / Day /Year |

## Section Four – Request to Waive Waiting Period *Must be completed and approved at time of hire

| Name of Employee | Date of Permanent Full Time Hire | Position |
|---|---|---|
| | Month/Day/Year | |
| Reason for Waiving Eligibility Period | | |
| | | |

## Section Five – Change / Update Salary

| Name of Employee | | |
|---|---|---|
| | | |
| Current Salary | New Salary | Effective Date |
| | | Month / Day /Year |

* Increased salary could require medical underwriting
* To be completed before increase in coverage is approved.

## Section Six – Change / Correct Occupation, Division or Class

Change in:
☐ Class
☐ Division
☐ Occupation

| Name of Employee |
|---|
| |
| Description of Change |
| |
| Effective Date |
| Month / Day /Year |

## Section Seven – Change / Add / Delete Plan Administrator

☐ Change Plan Administrator
☐ Add Plan Administrator
☐ Delete Plan Administrator

| Plan Administrator Name |
|---|
| |
| Plan Administrator Email |
| |
| Plan Administrator Phone Number |
| |
| Alternative Phone Number |
| |

## Section Eight – Change Company Address

| Street Address | | | Suite # |
|---|---|---|---|
| | | | |
| City | Province | Postal Code | Effective Date |
| | | | |

## Section Nine – Cohabitation Declaration

| Name of Employee | |
|---|---|
| | |
| Name of Cohabitant | Date of Cohabitation |
| | Month / Day /Year |

## Section Ten – Change Coverage Status – Waive, change to Single, Change to Family coverage

Change to:
☐ Waive Coverage (covered through spouse)
☐ Single
☐ Family

| Name of Employee | | |
|---|---|---|
| | | |
| Reason for change (Marriage; Separation/Divorce/Breakup; Spouse lost coverage; Spouse has Coverage; Other – provide details) | | |
| | | |
| Effective Date | | |
| Month / Day /Year | | |
| Spouse's Email Address | | |
| | | |
| Spouse's Employer Name | | Spouse's Employer Phone Number |
| | | |
| Spouse's Insurer Name | Spouse's Policy Number | Spouse's Group Coverage Effective Date |
| | | |

**Note:** You may need to update your beneficiary (see Form 1 – Section 9) and list any additional dependents (Form 1 – Section3).

## Section Eleven – Authorizations

**Name (printed)** _____ Position _____

**Signature of Employee** _____ Date _____

| Additional Comments/Notes |
|---|
| |
| |
| |
| |
| |
| |
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