info@ lewer.ca www.lewer.ca
3131 Saint-Martin Blvd. West, suite 410, Laval QC H7T 2Z5
(905) 821-9881 (800) 387-8244

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