



CDCS HEALTH CLAIMS INC.

58 Lisgar St., Suite 300, 3rd Floor, Sudbury, ON P3E 3L7 705-675-2222

P.O. Box 156 Stn. "A", Sudbury, ON P3E 4N5 800-265-2327

ENROLLMENT and CHANGE TRANSACTION FORM

GROUP #:	GROUP NAME:
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EMPLOYEE INFORMATION

TRANSACTION TYPE: <input type="checkbox"/> ADD; <input type="checkbox"/> DELETE; OR <input type="checkbox"/> CHANGE		EFFECTIVE DATE OF TRANSACTION: (d/m/y):	
IF TRANSACTION TYPE IS A CHANGE, INDICATE NATURE OF CHANGE:			
CERTIFICATE #:	DIVISION:	UNIT:	CLASS:
EMPLOYEE LAST NAME:		FIRST NAME:	
ADDRESS:		CITY:	POSTAL CODE:
PROV. OF RESIDENCE:	PROV. OF EMPLOYMENT:	BIRTH DATE: (d/m/y):	DATE HIRED: (d/m/y):
STATUS: <input type="checkbox"/> SINGLE OR <input type="checkbox"/> FAMILY		SEX: <input type="checkbox"/> MALE OR <input type="checkbox"/> FEMALE	

DEPENDANT INFORMATION

RELATIONSHIP TO EMPLOYEE If coverage then Inform? Or School?	ACTION A: Add D: Delete C: Change	EFFECTIVE DATE DATE (d/m/y)	LAST NAME IF DIFFERENT FROM EMPLOYEE	FIRST NAME	SEX (M/F)	DATE OF BIRTH (d/m/y)	STUDENT (Y/N). IF Y, THEN EXPECTED GRADUATION DATE (d/m/y)
SPOUSE							IF EMPLOYED SEE BELOW
CHILD							Y/N Graduation: / /
CHILD							Y/N Graduation: / /
CHILD							Y/N Graduation: / /
CHILD							Y/N Graduation: / /
CHILD							Y/N Graduation: / /

COORDINATION OF BENEFITS (COB) DECLARATION

COORDINATION OF BENEFITS between spousal plans is a method whereby one spouse's Plan is designated Primary, and the other is designated Secondary. The Primary Plan is the one with the spouse with the earlier birth date in the year (i.e. July 6 versus August 20), regardless of age. The Primary Plan pays first for all dependants claims and for his/her own claims. Claims submitted to a Secondary Plan for dependants must first have been submitted to the Primary Plan carrier. Failure to submit claims in the manner as described above and in accordance with the rules governing the Co ordination of Benefits, may result in any combination of the following:

Repayment in full to my employer for any spousal and/or dependant claims.

Payment to my employer for any legal and/or collection costs incurred.

I CERTIFY THAT MY SPOUSE

Check one: is not employed OR

has no Plan available OR

has a Plan available provided by _____ (Insurance Company or Plan Administrator), AND that my spouse if not currently enrolled in that Plan will now enroll in that Plan as provided by his/her employer.

I ALSO CERTIFY that if this status changes I will inform my employer and/or plan administrator immediately.

DATE: _____

SIGNATURE: _____

SPOUSAL EXEMPTION

IF SPOUSAL EXEMPTION IS REQUESTED PLEASE COMPLETE THE FOLLOWING:

I claim spousal exemption under the Plan because I have similar coverage with my Spouse's Plan.

My spouse is currently insured through a Plan underwritten by _____ (Insurance Company).

DATE: _____

SIGNATURE: _____

DATE: _____

GROUP AUTHORIZED SIGNATURE: _____