CDCS HEALTH CLAIMS INC.

1556 Lasalle Side Unit 3, Sudbury, ON P3A 1Z7

705-675-2222 800-265-2327 Fax 705-675-2376

BENEFIT CHANGE REPORT

EMPLOYER INFORMATION	
EMPLOYERS NAME:	**GROUP NUMBER**:

TYPE OF CHANGE:			
1.	**NEW ENROLMENT** – Attach completed enrolment form	**6.**	**SALARY CHANGE** – Show new salary in explanation Section
2.	**TERMINATION** – Indicate last day worked	**7.**	**BENEFICIARY CHANGE** – Attach completed change of beneficiary form
3.	**REINSTATEMENT/REHIRE** – Indicate previous termination date	**8.**	**TRANSFER** – Indicate old and new division in explanation section
4.	**CLASS CHANGE** – Show old and new class in explanation section	**9.**	**OTHER** – Provide details in explanation section
5.	**DEPENDENT STATUS CHANGE** – Show new status in explanation section. If adding new dependents attach completed insured dependent update form.		

EMPLOYEE BENEFIT CHANGE INFORMATION				
EMPLOYEE LAST NAME, FIRST NAME	**CERTIFICATE NUMBER**	**TYPE OF CHANGE**	**EFFECTIVE DATE (dd/mm/yyyy)**	**EXPLANATION**

EMPLOYER AUTHORIZATION		
NAME (Please Print)	**SIGNATURE**	**DATE SIGNED (dd/mm/yyyy)**