CDCS HEALTH CLAIMS INC.

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

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

DEPENDENT UPDATE FORM

EMPLOYEE INFORMATION

EMPLOYER NAME:		GROUP POLICY #:
EMPLOYEE NAME:		CERTIFICATE #:
ADDRESS:	CITY:	POSTAL CODE:

SPOUSE INFORMATION

EFFECTIVE DATE (d/m/y)	ACTION A: Add D: Delete C: Change	LAST NAME IF DIFFERENT FROM EMPLOYEE	FIRST NAME	SEX (M/F)	DATE OF BIRTH (d/m/y)	If your spouse has coverage with their employer, please indicate type of coverage and name of employer. Example: Family Health & Dental, Sample Company Ltd.

DEPENDENT INFORMATION

EFFECTIVE DATE (d/m/y)	ACTION A: Add D: Delete C: Change	LAST NAME IF DIFFERENT FROM EMPLOYEE	FIRST NAME	SEX (M/F)	DATE OF BIRTH (d/m/y)	If child is over 21, indicate if disable or if a full-time student. If in school provide name of school. Example: Full time student, University of Toronto, Sept 2003 – May 2005

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

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