CDCS HEALTH CLAIMS INC.

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

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

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, Unviersity 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)**