CG | BRITCAY

INFORMATION CHANGE REQUEST

Health Insurance

PART 1 EMPLOYEE DETAILS

Surname ______________________ First Name ______________________ Middle Initial(s) ________

Address ____

Contact Nos - Home ______________ Work ______________ Other ______________

Group Name/No. ______________________ Certificate No. ______________

Position/Job Title ______________________ Date of Birth (DD/MM/YY) ______________

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

PART 2 TYPE OF CHANGE REQUESTED (please tick all that apply)

1. ☐ Change coverage to: ☐ SHIC ☐ Individual ☐ SHIC Plus ☐ Family ☐ Provident Plan ☐ Individual & Child ☐ Premier Health ☐ Individual & Children

   If adding a spouse, please attach a copy of the Marriage Certificate and advise date of marriage ______________

   If adding an adopted child, please attach a copy of the Adoption Certificate and advise date of adoption ______________

   If adding a child with a different last name, please include a copy of their Birth Certificate.

2. ☐ Remove a Dependent OR ☐ Add a Dependent For either adding or removing a Dependent, complete chart below:

   If removing a family member, give reason and effective date: ______________________

Added/Removed Dependent(s) (Surname, First Name, Initials)	Date of Birth (DD/MM/YY)	Relationship

3. ☐ Change address to address noted in Part I.

4. ☐ Change name from ______________________ to name noted above.

   Please attach supporting documentation proving name change.

PART 3 SIGNATURES

Signature of Employee ______________________ Date ______________

Signature of Employer ______________________ Date ______________

FOR OFFICE USE	Service Code:	Effective Date of Coverage:

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Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

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