

Plan Sponsor Information				
Employer/Company Name				
Group No.	Division No.	Unit No.	Certificate No.	
Add <input type="checkbox"/>	Action Code Change <input type="checkbox"/>	Delete <input type="checkbox"/>	Effective Date of Action (dd/mm/yy)	

Plan Member Information				
Surname			First Name	
Address		City or Town	Province	Postal Code
Date of Birth (dd/mm/yy)	Date of Hire (dd/mm/yy)	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Language English <input type="checkbox"/> French <input type="checkbox"/>	

Dependent Information							
Surname	First Name	Date of Birth (dd/mm/yy)	Relationship to Member	Effective Date (dd/mm/yy)	Action Code Add/ Change/ Delete	Gender	
						Female <input type="checkbox"/>	Male <input type="checkbox"/>
						Female <input type="checkbox"/>	Male <input type="checkbox"/>
						Female <input type="checkbox"/>	Male <input type="checkbox"/>
						Female <input type="checkbox"/>	Male <input type="checkbox"/>
						Female <input type="checkbox"/>	Male <input type="checkbox"/>
						Female <input type="checkbox"/>	Male <input type="checkbox"/>

**Note: Relationship to member: Spouse, Child, Disable or OverAge Dependent (If OverAge Dependent complete below)**

OverAge Dependent Information (OAD)					
Surname	First Name	Date of Birth (dd/mm/yy)	School Start Date	School End Date	School Name (Optional)
				August 31/ _____	
				August 31/ _____	

**Note: Coverage for OAD terminates on August 31st of each year therefore, the member must re-apply if the child re-enrolls the next school year**

Benefit Coverage Information											
Member Coverage Status						Spousal Coordination of Benefit Status					
Family <input type="checkbox"/>	Health Single <input type="checkbox"/>	Waive <input type="checkbox"/>	Dental Family <input type="checkbox"/>	Single <input type="checkbox"/>	Waive <input type="checkbox"/>	Family <input type="checkbox"/>	Health Single <input type="checkbox"/>	N/A <input type="checkbox"/>	Dental Family <input type="checkbox"/>	Single <input type="checkbox"/>	N/A <input type="checkbox"/>
For <b>Quebec</b> residents age 65 or over, select the senior ID code: Member: RAMQ <input type="checkbox"/> Both <input type="checkbox"/> Private <input type="checkbox"/> / Spouse: RAMQ <input type="checkbox"/> Both <input type="checkbox"/> Private <input type="checkbox"/>											

**AUTHORIZATION**  
 I hereby authorize ClaimSecure to use my Social Insurance Number, where required, to administer my health and dental benefit plan. I also authorize ClaimSecure, healthcare providers, insurers, administrators of government or other benefit plans and other service providers working with ClaimSecure to exchange necessary information to administer my health and dental benefit plan. I confirm that I am authorized to act on behalf of myself, my spouse and dependents when applying for coverage, or for purposes of the ongoing administration of my health and dental benefit plan.

Plan Member Authorization		
Signature of Plan Member	Print Name	Date signed (dd/mm/yy)
_____	_____	_____
Plan Sponsor Authorization		
Signature of Plan Administrator	Print Name	Date signed (dd/mm/yy)
_____	_____	_____

**Please complete form and send to:**  
 E-mail: [eligibilityupdates@claimsecure.com](mailto:eligibilityupdates@claimsecure.com) Fax: 1-705-673-5968  
 or mail: CLAIMSECURE INC. PO BOX 6500 STN A SUDBURY ON P3A 5N5 Phone: 1-888-513-4464