HEALTH ASSOCIATION NOVA SCOTIA

PERSONAL INFORMATION CHANGE FORM

PERS

TO BE COMPLETED BY EMPLOYEE

(Complete only those areas requiring a change. **Please print and use capital letters**. *Additional forms may be required, depending on the personal information change.*

Last Name	First Name	Middle Initial	Certificate Number

❒ Name Change

From (Last name, first name and Initial)	To (Last name, first name and initial)

❒ New Address

Street and no.	City/town	Province	Postal code

❒ New Telephone Number ❒ New Email Address

New Phone Number	New Email

❒ Change in Marital Status Please complete if you are adding or removing your spouse.

Please Note: Your spouse will be added to those benefits that are currently at family status. If you would like to change your status or apply for Optional Life and/or Critical Illness for this spouse please complete a **Benefit Change Form**.

Last Name of Spouse	First Name of Spouse	Middle Initial

Date of Birth (mm/dd/yyyy)	Gender	Effective Date (mm/dd/yyyy)

Action* (*D – Delete, A – Add, C – Change)	Married (mm/dd/yyyy)	Common-law spouse – date of cohabitation (mm/dd/yyyy)	
	Widowed – (mm/dd/yyyy)	Separated (mm/dd/yyyy)	Divorced (mm/dd/yyyy)

❒ New/Change Children Information

Action*	Last name	First name	Initial	Gender	Date of birth			Dependent status**
					MM	DD	YYYY	
	02 -							
	03 -							
	04 -							

* D – Delete, A – Add, C – Change ** CH – Child, E – Student (college/university), S – Disabled

Please indicate any other dependent children on an additional application form. If the dependent child is between ages 21 and 26, you must provide proof that your child is attending an accredited educational institution on a full-time basis. If the child is disabled, please see your benefit administrator for the appropriate forms.

DECLARATION AND AUTHORIZATION

I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, administering changes to benefits coverage, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of determining their eligibility for benefits and any of the uses set out above.

I have verified the information on this form and declare that it is accurate and complete. I authorize my employer to deduct from my earnings required contributions for coverage under these plans.

_____ _____

Date (MM/DD/YYYY) Signature of Employee

TO BE COMPLETED BY EMPLOYER ONLY

Division name (include site/location/zone)	Division number

Employee name	Payroll Number

We hereby certify that this person is an eligible employee.

_____ _____

Name of Authorized Benefits Administrator (Please Print) Signature of Authorized Benefits Administrator

_____

Date (MM/DD/YY/YY)

Notes

Employer - Please upload to your facility folder on our secure SharePoint site. Please do not also forward the original to Health Association Nova Scotia – Keep the original for your records.