



## DRUG AND HEALTH INSURANCE PLAN MODIFICATION REQUEST

### GENERAL INFORMATION

Family name:	Given name:	Identification number:
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### CHANGE OF ADDRESS

Address: <input type="checkbox"/> Residence <input type="checkbox"/> Office		Modification date:
City and province:		Postal code:
Tel. (office): (     )	Tél. (residence): (     )	Fax number: (     )

### CHANGE OF OPTION

<b>OPTION 1</b> – Less than age 65 (Drug Insurance only)	<input type="checkbox"/> Individual	<input type="checkbox"/> Couple	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family
<b>OPTION 2</b> - Less than age 65 (Drug and Health Insurance)	<input type="checkbox"/> Individual	<input type="checkbox"/> Couple	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family
<b>OPTION B</b> – Age 65 and over (Health Insurance only)	<input type="checkbox"/> Individual	<input type="checkbox"/> Couple	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family

**IMPORTANT NOTICE :** *Participant must maintain his choose of option for a minimum period of two (2) years before requesting a change of option.*

### CHANGE OF STATUS

- a) Marriage;
- b) When the spouse becomes eligible (12 months cohabitation or birth of child);
- c) Birth or adoption of a dependent child;
- d) Death of the spouse or a dependent child;
- e) On termination of a dependent child's eligibility;
- f) When the spouse acquires or loses the right to enrol in employer's group plan.

Please indicate the event justifying the change \_\_\_\_\_ Date of the event AA / MM / DD

<b>COVERAGE</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Couple	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family
Dependent name	Sex	Date of birth	Health Insurance Card Number	Status of dependent E: Full time student (aged 21 to 25 inclusively)

### CANCELLATION

**I WILL BE COVERED UNDER MY :** SPOUSE  EMPLOYER  INSURANCE PLAN

(It is important to note that Law 33 requires you to have a drug insurance coverage. Furthermore, you are not eligible to the RAMQ drug insurance plan if you are less than 65 years old.)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_