



Change in Coverage/Addition of Dependents

Date: _____ Name of Employer: _____ Policy Number TS _____

Administrator's Name: _____ Email: _____

Reason for Change: Addition or Deletion of Spouse/Partner Addition or Deletion of Child

Effective Date of Change: _____

PART 1 – Employee Information

Name of Employee		Certificate Number
Address		
City	Province	Postal Code
Phone Number		Sex(M/F)
Date of Birth (MM/DD/YYYY)		Email address
Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family		Effective Date of Coverage (MM/DD/YYYY)

PART 2 – Dependent Information

Spouse Name	Sex(M/F)	Date of Birth (MM/DD/YYYY)
Child 1 Name	Sex(M/F)	Date of Birth (MM/DD/YYYY)
Child 2 Name	Sex(M/F)	Date of Birth (MM/DD/YYYY)
Child 3 Name	Sex(M/F)	Date of Birth (MM/DD/YYYY)
Child 4 Name	Sex(M/F)	Date of Birth (MM/DD/YYYY)

Employee Signature: _____ Employer Signature: _____



TEN STAR Group Benefit Specialists Inc.

Please submit this form by mail to:
 Ten Star Group Benefit Specialists Inc.
 95 Hamilton Street North, Suite 2, P.O. Box 1490, Waterdown, Ontario L0R 2H0
 OR by Fax: (905) 689-1885 or toll-free (866) 269-5510
 OR by email to groupdept@tenstar.ca