EMPLOYEE BENEFITS LTD.

Employee Change Card

A & W REGIONAL FRANCHISE ASSOCIATION

Employee's Surname	First Name	Middle Initial	Social Insurance Number	Gender ☐ Male ☐ Female	Birthdate YY MM DD	Policy Contract Number
Registered Name of Employer						Effective Date of Employee Change

EMPLOYEE CHANGE: CHECK REQUIREMENT AND PROVIDE REQUESTED INFORMATION

Change: ☐ Name ☐ Address ☐ Salary ☐ Class ☐ Coverage ☐ Location ☐ Terminate Employee

Restaurant Location Change

Employee Former Name	Reason for Change	Reason for Termination	Employee Address
Complete for Change of Name	***Complete for Change of Coverage*** ☐ Single ☐ Family	***Complete for Employee Termination***	

New Earnings	Hr / Wk / Bi Wk / Mo / Yr	Average Number of Hours Worked per Week	New Class
Complete for Change of Salary $			***Complete for Change of Class***

City

Prov. Postal Code

DEPENDENT CHANGE: CHECK REQUIREMENTS AND PROVIDE REQUESTED INFORMATION

Change: ☐ Add ☐ Terminate

If Adding Spouse, Check One and Enter Date	*If Spouse Previously Covered, Show Name of Insurance Company and Benefits Covered*	*Group Number and Previous Coverage*	***Termination Date of Previous Coverage*** YY MM DD
☐ Date of Marriage ☐ Date of Cohabitation YY MM DD			

In this column:

1) If adding student age 21 or over, indicate name of School/University.
2) If dependent child is handicapped, please indicate nature of handicap.
3) If adding adopted child or ward, provide date you legally became the child's guardian.
4) If deleting dependent(s), give reason.
5) If changing dependent's name, indicate former name.

First Name	Initial	Surname	Gender M/F	Birthdate YY	MM	DD	Termination Date YY	MM	DD	

I hereby agree that all statements and answers included in this application are true and complete

Signature of Employer

Signature of Employee

Date Signed

Please TYPE or PRINT clearly in ink

Please complete and return by Fax or Mail to:

HMR EMPLOYEE BENEFITS LTD.
220-2186 Oak Bay Ave.
Victoria, BC
V8R 1G3
Tel: (250) 592-4614
Toll Free: 1-888-592-4614
Fax: (250) 592-4953