



ENROLLMENT/MODIFICATION FORM
Concordia University's Drug and Health Insurance Plans
Part-Time Teachers
THIS FORM MAY BE COMPLETED ON YOUR SCREEN AND PRINTED

EMPLOYEE INFORMATION

Name _____ Policy Number _____
 Employee ID Number _____ Date of Birth _____ / _____ / _____
 Year Month Day

COVERAGE OPTIONS

Single _____ Single parent _____ Opt out (possible only if you have coverage elsewhere; you must attach proof of that coverage) _____
 Couple _____ Couple with children _____

DEPENDENT INFORMATION

If you have selected coverage for your spouse and/or dependent children, please provide the following information for the person(s) covered.

	First Name (in full)	Last Name (if different from your last name)	Date of Birth (year/month/day)	Sex		Status	
				F	M	Full-time student	Disabled (children only)
Spouse	_____	_____	____/____/____				N/A
Child 1	_____	_____	____/____/____				
Child 2	_____	_____	____/____/____				
Child 3	_____	_____	____/____/____				
Child 4	_____	_____	____/____/____				
Child 5	_____	_____	____/____/____				
Child 6	_____	_____	____/____/____				

COORDINATION OF BENEFITS

If your spouse and/or children are also covered under another health insurance plan, they may claim under both plans (coordination of benefits). A spouse who is also covered under his/her employer's plan must submit claims to that employer's plan first, and a university student who is also covered under a university student plan must submit claims to the student plan first. Any remaining costs can then be submitted under Concordia's plan.

If your dependent children have coverage under a former spouse's plan, you must attach a separate note with details about their coverage.

My **spouse** has the following health insurance coverage under his/her employer's plan:
 Single _____ Family _____ None _____

My **dependent children who are full-time students** have coverage under a student health plan:
 Child's Name _____
 Child's Name _____
 Child's Name _____

AUTHORIZATION

I understand that the insurance carrier will use the information on this form to process my claims. I certify that the information provided is true, correct and complete to the best of my knowledge. I also understand that I may be required to provide proof of this information. I authorize the University to make any necessary payroll deductions to pay for the coverage I have selected.

Employee's Signature X _____ Date _____ / _____ / _____
 Year Month Day

IMPORTANT:

- ✓ Please return this form, duly completed and signed, to: Benefits Services, S-FB 1130, Concordia University, 1455 de Maisonneuve Blvd. W., Montreal, Quebec H3G 1M8.
- ✓ If you do not return this form, you will automatically have single coverage under the plan.
- ✓ No claims will be paid for any individual who has not been registered as an eligible dependent.