Dependent Status Change

Please submit completed form to BBD:
500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
Fax: 604.464.7997 Toll Free: 800.667.1336

Name of Employer:

▶ *To use this form you must already be insured under your employer's plan. For a new enrolment complete a Group Insurance Enrollment form.* ◀

▶ Employee – Complete this section ◀

Employee Last Name	First Name	Initial	Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

Dep. No.	List Dependents Last Name	First Name	Initial	Sex M/F	Birth Date Month	Day	Year	Relationship to You	If child is over plan's age limit (e.g. 19 or 21), and attending school full-time, provide name of school. If
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

Reason for Dependent Status Change (check one and provide details)

☐ Marriage (complete dependent information)
Date of marriage_____

☐ Common Law Spouse (complete dependent information)
Date of cohabitation_____

☐ Birth or Adoption of Child (complete dependent information)
If adoption, provide date_____

☐ Child(ren) of Common Law Spouse
(must reside with you – complete dependent information)
Date of acquiring dependent(s) _____

☐ Separation
Date of separation _____
Is spouse still to be covered? ☐ Yes ☐ No
Are children still to be covered? ☐ Yes ☐ No
(if no, complete Partial Waiver section)

☐ Death of Dependent
Date of death_____
Dependent Name_____
Relationship _____

☐ Divorce
Date of divorce _____
Is former spouse still to be covered? ☐ Yes ☐ No
Are children still to be covered? ☐ Yes ☐ No
(if no, complete Partial Waiver section)

☐ Other (specify – include date of change)
_____
_____
_____

Partial Waiver

▶ Employee – Complete for partial waiver due to coverage under another group plan ◀

Employee Last Name	First Name	Initial	Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)

▶ For myself and my dependents .....☐ Extended Health Care ☐ Dental Care **OR** ▶ For my dependents only .....☐ Extended Health Care ☐ Dental Care

Name of Other Plan's Employer/Policyholder	Is this your spouse's group plan? ☐ Yes ☐ No (if no, provide details)
Name of Insurance Company	
Group Number Identity Number	