3sHealth – Employee Benefits
600-1919 Saskatchewan Drive Regina, SK S4P 4H2
T. 306-347-5519 F. 306-347-5910
Toll Free: 1-866-278-2301
Email: ebp@3sHealth.ca

Employee Benefits Dependent Change Form

PERSONAL INFORMATION

First Name	Last Name	BID Number
Date of Birth	Email address	Daytime Phone Number

ADD OR CHANGE INFORMATION ABOUT YOUR SPOUSE:

Marital Status ❑ Married ❑ Common-law Relationship	Has Your Marital Status Changed? ❑ Yes ❑ No
Relationship Effective Date	Represents the date you were legally married or the date that you started living together as common-law (A common-law spouse is a person you have been living with in a spousal relationship for the past 12 months, forming a common-law relationship)

First Name	Last Name	Date of Birth
Information Change Effective Date		

REMOVE YOUR SPOUSE:

First Name	Last Name	Date of Birth
Removal Effective Date		

ADD, CHANGE OR REMOVE INFORMATION ABOUT DEPENDENT CHILDREN:

Dependent 1

❑ Add Dependent ❑ Remove Dependent ❑ Change Dependent

First Name	Last Name	Date of Birth

Dependent Child 1 is Mentally or Physically Challenged ❑ Yes ❑ No	Dependent Child 1 is a University/Post Secondary Student ❑ Yes ❑ No
Information Change Effective Date	If you have a child between the ages of 21 and 25 who is attending an accredited College or University, complete, sign and send the **Dependent Verification Form** to 3sHealth each calendar year.

Dependent 2

❑ Add Dependent ❑ Remove Dependent ❑ Change Dependent

First Name	Last Name	Date of Birth

Dependent Child 2 is Mentally or Physically Challenged ❑ Yes ❑ No	Dependent Child 2 is a University/Post Secondary Student ❑ Yes ❑ No
Information Change Effective Date	If you have a child between the ages of 21 and 25 who is attending an accredited College or University, complete, sign and send the **Dependent Verification Form** to 3sHealth each calendar year.

Dependent 3

❑ Add Dependent ❑ Remove Dependent ❑ Change Dependent

First Name	Last Name	Date of Birth

Dependent Child 3 is Mentally or Physically Challenged ❑ Yes ❑ No	Dependent Child 3 is a University/Post Secondary Student ❑ Yes ❑ No
Information Change Effective Date	If you have a child between the ages of 21 and 25 who is attending an accredited College or University, complete, sign and send the **Dependent Verification Form** to 3sHealth each calendar year.

PERSONAL INFORMATION

First Name	Last Name	BID Number
Date of Birth	Email address	Daytime Phone Number

ADD, CHANGE OR REMOVE INFORMATION ABOUT DEPENDENT CHILDREN:

Dependent 4

❑ Add Dependent ❑ Remove Dependent ❑ Change Dependent

First Name	Last Name	Date of Birth

Dependent Child 4 is Mentally or Physically Challenged ❑ Yes ❑ No	Dependent Child 4 is a University/Post Secondary Student ❑ Yes ❑ No
Information Change Effective Date	If you have a child between the ages of 21 and 25 who is attending an accredited College or University, complete, sign and send the **Dependent Verification Form** to 3sHealth each calendar year.

Dependent 5

❑ Add Dependent ❑ Remove Dependent ❑ Change Dependent

First Name	Last Name	Date of Birth

Dependent Child 5 is Mentally or Physically Challenged ❑ Yes ❑ No	Dependent Child 5 is a University/Post Secondary Student ❑ Yes ❑ No
Information Change Effective Date	If you have a child between the ages of 21 and 25 who is attending an accredited College or University, complete, sign and send the **Dependent Verification Form** to 3sHealth each calendar year.

Dependent 6

❑ Add Dependent ❑ Remove Dependent ❑ Change Dependent

First Name	Last Name	Date of Birth

Dependent Child 6 is Mentally or Physically Challenged ❑ Yes ❑ No	Dependent Child 6 is a University/Post Secondary Student ❑ Yes ❑ No
Information Change Effective Date	If you have a child between the ages of 21 and 25 who is attending an accredited College or University, complete, sign and send the **Dependent Verification Form** to 3sHealth each calendar year.

Acknowledgement: I hereby acknowledge that I have read and understand the conditions of the Employee Benefit Plans, as outlined in the Plans' commentaries available online at www.3sHealth.ca, and confirm the options I have chosen above. I understand these benefits are subject to the terms of the Group Life Insurance Plan, Disability Plan, Core Dental Plan, Enhanced Dental Plan and Extended Health Care Plan, as applicable, sponsored by Health Shared Services Saskatchewan.

I hereby expressly consent to the collection, use, and disclosure of my personal information by 3sHealth for the purpose of administering my benefits, for the purpose of sharing my information with future or replacement service providers relating to the administration of my benefits, and as otherwise provided in the 3sHealth Privacy Policy (available online at www.3sHealth.ca). I further consent to 3sHealth using my personal information in other 3sHealth systems, including the payroll system, where required for the administration or payment of my benefits.

By submitting this form, I agree that the information provided is complete and accurate.

3sHealth Employee Benefits is committed to protecting the privacy of your personal information. We collect and use your personal information to determine your eligibility for coverage and to administer the benefit plans. We limit access to your personal information to 3sHealth Employee Benefits staff, to any third party authorized by 3sHealth who requires it to administer your benefits, to persons to whom you have granted access, and to persons authorized by law.

Save this form to your computer (Ctrl-s; hold down the Control key and press "s"), fill it out, save it, and attach the filled out version in an email to ebp@3sHealth.ca