

## Employee Benefits Dependent Change Form

### PERSONAL INFORMATION

First Name	Last Name	BID Number
Date of Birth (dd/mm/yyyy)	Email address	Daytime Phone Number

### ADD OR CHANGE INFORMATION ABOUT YOUR SPOUSE:

Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Common-law Relationship    Has Your Marital Status Changed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship Effective Date (dd/mm/yyyy)	Represents the date you started living together as Common-Law (must be 12 months or more) or the date you were legally married. Select or enter the relationship effective date in the format	
First Name	Last Name	Date of Birth (dd/mm/yyyy)
Information Change Effective Date (dd/mm/yyyy)		

### REMOVE YOUR SPOUSE:

First Name	Last Name	Date of Birth (dd/mm/yyyy)
Removal Effective Date (dd/mm/yyyy)		

### ADD, CHANGE OR REMOVE INFORMATION ABOUT DEPENDENT CHILDREN:

<b>Dependent 1</b>	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Change Dependent	
First Name	Last Name	Date of Birth (dd/mm/yyyy)
Dependent Child 1 is Mentally or Physically Challenged <input type="checkbox"/> Yes <input type="checkbox"/> No		Dependent Child 1 is a University/Post Secondary Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Information Change Effective Date (dd/mm/yyyy)		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 <b>Dependent Verification Form</b> to 3sHealth each calendar year.

<b>Dependent 2</b>	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Change Dependent	
First Name	Last Name	Date of Birth (dd/mm/yyyy)
Dependent Child 2 is Mentally or Physically Challenged <input type="checkbox"/> Yes <input type="checkbox"/> No		Dependent Child 2 is a University/Post Secondary Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Information Change Effective Date (dd/mm/yyyy)		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 <b>Dependent Verification Form</b> to 3sHealth each calendar year.

<b>Dependent 3</b>	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Change Dependent	
First Name	Last Name	Date of Birth (dd/mm/yyyy)
Dependent Child 3 is Mentally or Physically Challenged <input type="checkbox"/> Yes <input type="checkbox"/> No		Dependent Child 3 is a University/Post Secondary Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Information Change Effective Date (dd/mm/yyyy)		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 <b>Dependent Verification Form</b> to 3sHealth each calendar year.

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## ADD, CHANGE OR REMOVE INFORMATION ABOUT DEPENDENT CHILDREN:

<b>Dependent 4</b>	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Remove Dependent	<input type="checkbox"/> Change Dependent
First Name	Last Name	Date of Birth (dd/mm/yyyy)	
Dependent Child 4 is Mentally or Physically Challenged <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Child 4 is a University/Post Secondary Student <input type="checkbox"/> Yes <input type="checkbox"/> No		
Information Change Effective Date (dd/mm/yyyy)	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 <b>Dependent Verification Form</b> to 3sHealth each calendar year.		

<b>Dependent 5</b>	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Remove Dependent	<input type="checkbox"/> Change Dependent
First Name	Last Name	Date of Birth (dd/mm/yyyy)	
Dependent Child 5 is Mentally or Physically Challenged <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Child 5 is a University/Post Secondary Student <input type="checkbox"/> Yes <input type="checkbox"/> No		
Information Change Effective Date (dd/mm/yyyy)	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 <b>Dependent Verification Form</b> to 3sHealth each calendar year.		

<b>Dependent 6</b>	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Remove Dependent	<input type="checkbox"/> Change Dependent
First Name	Last Name	Date of Birth (dd/mm/yyyy)	
Dependent Child 6 is Mentally or Physically Challenged <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Child 6 is a University/Post Secondary Student <input type="checkbox"/> Yes <input type="checkbox"/> No		
Information Change Effective Date (dd/mm/yyyy)	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 <b>Dependent Verification Form</b> 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](http://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](http://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.

Print a Copy (Ctrl-p)

Clear Form Fields

**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](mailto:ebp@3sHealth.ca)**