HUMANIA ASSURANCE MD®

Notification of change

Firm's name : _____

Group N° : | | | | | | Subdivision: | | |

Certificate Number	Employee (Name) (First name)	Code *	Date of change Y	M	D	Salary Weekly or Annual	Additional Information (if necessary)

Code *

1- New employee (fill out and sign the group insurance application form)
2- Final termination of employment
3- Return to work full time
4- Change of salary
5- End of disability and return to work
6- Individual coverage
7- Family coverage
8- Family coverage (without spouse)
9- Beneficiary (fill out and sign the form)
10- Change of name
11- Temporary termination of employment (health insurance (Medical Benefit insurance) is the only coverage in force)
12- Temporary termination of employment (only the disability income coverages are cancelled)
13- Temporary termination of employment (without coverage)
14- Addition of dependant
15- Change of address
16- Exemption Health and/or Dental insurance (join attestation of insurance)
17- Other (specify)

**** Important notice****

A- Any changes should be reported to the insurer within a maximum period of 30 days.

B- Refer to your administrative guide for details.

C- For adding a dependant, write the name, sex and date of birth. Also fill out and sign the marital status form for adding a spouse.

_____
Autorized by (print)

_____ _____
Date Signature

The personal information contained in this document will be deposited in the policyholder file. You have the right to examine the personal information contained in this file and, if required, to have it corrected by sending a written request to the policyholder.