Public Service Health Care Plan (PSHCP) Positive Enrolment Change Form

Sun Life Financial

Date amendment requested (dd-mm-yyyy)

Contract number **055555**

Certificate number

Instructions

- You can complete this form online at **www.sunlife.ca/enrolment_pshcp**, rather than submitting a paper form.
- If you need to add more dependants or make changes to more than one dependant, use a photocopy of this form.
- Print clearly in ink, and sign and date the form and mail it.

Questions? Visit **www.sunlife.ca/enrolment_pshcp** or call toll free 1-877-283-1411 or, in the National Capital Region, 613-560-7846, Monday to Friday, 6:30 a.m. to 8:00 p.m. EST.

Complete this section.

Last name	First name	Date of birth (dd-mm-yyyy)

Complete only the sections you want to change.

1 Your contact information

Permanent address (street number and name, and/or P.O. Box)	Apartment	City

Province/State	Postal code/Zip code	Country	Telephone number

2 Your coordination of benefits information

Are you covered under another private group health care plan, other than the PSHCP? ☐ Yes ☐ No If yes, for ☐ Drugs only ☐ Medical only ☐ Drugs and medical ☐ Other	If yes, are you covered as ☐ Employee ☐ Retiree ☐ Dependant	Is the coverage ☐ Single ☐ Family

3 Information about your spouse/common-law partner

☐ **Cease coverage**

☐ **Add a spouse/common-law partner (if you have family coverage)**

☐ **Change information about a spouse already enrolled**

Last name	First name	Gender ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Spouse/common-law partner's coordination of benefits

Is your spouse/common-law partner a member of the PSHCP (other than as your dependant)? ☐ Yes ☐ No	If yes, provide your spouse/common-law partner's PSHCP certificate number
Is your spouse/common-law partner covered under another private group health care plan? ☐ Yes ☐ No If yes, for ☐ Drugs only ☐ Medical only ☐ Drugs and medical ☐ Other If yes, as a ☐ Member ☐ Dependant **(Select "member" if both apply.)**	Is the other plan coverage ☐ Single ☐ Family

4 Information about your dependant children

☐ **Cease coverage**

☐ **Add a dependant child (if you have family coverage)**

☐ **Change information about a dependant child already enrolled**

Last name	First name	Gender ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Relationship ☐ Son ☐ Daughter ☐ Foster child	Full-time student (if over age 20) ☐ Yes ☐ No	Child with a disability ☐ Yes ☐ No

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For HO use only:
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Certificate number

4 Information about your dependant children (continued)

Dependant's coordination of benefits

Is your dependant child covered under another private group health care plan? ☐ Yes ☐ No If yes, for ☐ Drugs only ☐ Medical only ☐ Drugs and medical ☐ Other	If yes, as ☐ Member ☐ Dependant **(Select "member" if both apply.)**
If dependant under another private group health care plan:	
Date of birth of parent covered under that plan (dd-mm-yyyy)	First name of parent with other coverage

5 Consent to release of personal information and signature

Definitions

The Plan Sponsor is the Government of Canada.

The Plan Administrator is Sun Life Assurance Company of Canada.

The Public Service Health Care Plan (PSHCP) Administration Authority is the corporation charged with the administration of the PSHCP.

Personal information, for the purposes of this Consent, means the personal information described in the PSHCP Privacy Statement.

I have read and I understand the PSHCP Privacy Statement provided to me and that Sun Life Assurance Company of Canada has been retained to provide the administrative services for the PSHCP.

- I authorize the Plan Sponsor, the PSHCP Administration Authority and the Plan Administrator, its agents and service providers, to use and disclose personal information about me and my eligible dependants, for the administration of the PSHCP and for the adjudication of claims;
- I authorize the Plan Sponsor, the PSHCP Administration Authority and the Plan Administrator, its agents and service providers, to use and disclose personal information with other persons and organizations who have, or require, relevant personal information about me and my eligible dependants pertaining to our claims;
- I certify that my spouse and my eligible dependants 18 years of age and over consent to their enrolment in the PSHCP and to the disclosure of their personal information for that purpose;
- I certify that my spouse and my eligible dependants 18 years of age and over authorize the use and disclosure of their personal information for the additional purposes identified above;
- I agree to disclose personal information about my eligible dependants under 18 years of age in order to enrol them in the Plan, and I authorize the use and disclosure of their personal information for the additional purposes identified above;
- I certify that all dependants named on this form meet the PSHCP eligibility requirements and that the information provided above is complete and accurate;
- I agree to notify the Plan Administrator of any changes to the information provided above;
- I certify that all goods and services for which reimbursement is claimed will have been received by me, my spouse or my eligible dependants, including any dependant 18 years of age and over.

A photocopy or electronic version of this signed authorization is as valid as the original.

Member signature X	Date (dd-mm-yyyy)

Keeping your information confidential

At all times, the information collected through positive enrolment will be protected under the provisions of the *Personal Information Protection and Electronic Documents Act (PIPEDA)*.

Mailing instructions – keep a copy of this form for your records

Mail your completed and signed form to:

Sun Life Financial
PSHCP Positive Enrolment
PO Box 2005, Stn Waterloo
Waterloo ON N2J 0A4

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