Form 803114/Feb. 2015

Toronto Transit Commission
Benefit Services, Human Resources Department

To avoid delays and errors in processing please fully complete applicable sections and print clearly.

Healthcare and Dental Coverage / Dependents Change of Information

Employee No.	Employee Name (Print Full Name i.e. first/last name)	Department	Section

PART 1 REQUEST CHANGE IN HEATHCARE AND DENTAL COVERAGE

From: ☐ Single ☐ Family **To:** ☐ Single ☐ Family

PART 2 FAMILY COVERAGE INFORMATION - DEPENDENT(S)

Please see Definitions on the back of this form, eligible dependent(s) must meet one of the listed definitions.

SPOUSE

ADD SPOUSE (Print Full Name i.e. first/last name)	Sex	Date of Birth DD MM YY	Resident of Canada	Covered by OHIP
			☐ Yes ☐ No	☐ Yes ☐ No

Reason for additions (check one only)

◯ Marriage | Date of Marriage (dd/mmm/yyyy) | ◯ Common-law | Date Commenced (dd/mmm/yyyy)

DELETE SPOUSE FROM COVERAGE — Print Full Name (i.e. first/last name) — Date of Birth DD MM YY

Effective Date of Termination | Reason for Termination

CHILD

CHILD/STUDENT INFORMATION (use additional forms as required)

Child Relationship: Natural (N) Adopted (A) Legal Custody/Guardianship (LG)

Print Full Name (i.e. first/last name)	Add (A) Delete (D) A	D	Sex	Relationship to: Employee N	A	LG	Spouse N	A	LG	Date of Birth DD MM YY	Resides with you Yes	No	Resident of Canada Yes	No	Covered by OHIP Yes	No	Disabled Dependent Yes
1.	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐
2.	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐
3.	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐

STUDENT

STUDENT INFORMATION - AGE 21 to 25

	Print Full Name (i.e. first/last name)	Date of Birth DD MM YY	Sex
1.	Name of recognized Educational Institution in which enrolled on a full-time basis (i.e. minimum 15 hours/week)	City	Province Country
	Print Full Name (i.e. first/last name)	Date of Birth DD MM YY	Sex
2.	Name of recognized Educational Institution in which enrolled on a full-time basis (i.e. minimum 15 hours/week)	City	Province Country

PART 3 CO-ORDINATION OF BENEFITS

To ensure proper payment of benefit claims and to minimize delays in claims processing, please provide details of benefit entitlement under any other plan.

1. Is your spouse or former spouse a TTC employee / pensioner? ☐ Yes ☐ No **If Yes, please fully complete below.**

Print Full Name (i.e. first/last name)	Employee/Pensioner No.	Date of Birth DD MM YY

2. Does your spouse have benefits coverage under any other plan? ☐ Yes ☐ No **If Yes, please fully complete below.**

Print Full Name (i.e. first/last name)	Date of Birth DD MM YY	Sex	Date this coverage effective: DD MM YY	terminated: DD MM YY	Coverage:	Single	Family	None
					HEALTHCARE	☐	☐	☐
					DENTALCARE	☐	☐	☐

If your spouse has family coverage, name the dependent(s) who are covered under this plan:

3. Does your former spouse, who shares dependent(s) with you, have benefits coverage under any other plan? ☐ Yes ☐ No **If Yes, please fully complete below.**

Print Full Name (i.e. first/last name)	Date of Birth DD MM YY	Sex	Date this coverage effective: DD MM YY	terminated: DD MM YY	Coverage:	Single	Family	None
					HEALTHCARE	☐	☐	☐
					DENTALCARE	☐	☐	☐

If your former spouse has family coverage, name the dependent(s) who are covered under this plan:

I confirm that the information I have provided is accurate and truthful. I understand that providing false information will result in loss of benefit coverage and that I may be subject to disciplinary action up to and including the termination of employment. I consent and authorize the TTC's benefit carrier to release and exchange with the TTC, any information relating to any and all benefit claims submitted by me, or on behalf of my Dependent, for the purposes of prevention, detection and suppression of fraud, including but not limited to investigation or restitution, or employment management.

X _____ _____

Employee's Signature **Date**

Personal information is collected under the authority of the *City of Toronto Act,* 2006, S.O. 2006, c.11, Schedule A, including but not limited to Part XVII, and the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M.56. This information is used for the purpose of enrolling the employee and eligible dependent(s) for healthcare coverage with the Commission's health insurance carrier. Questions about this collection can be directed to Benefit Services, Human Resources Dept., Toronto Transit Commission, 1138 Bathurst St., Toronto, Ontario M5R 3H2, 416-393-2635/4370.

Distribution: White - Payroll & Benefit Accounting, Finance Dept. 1900 Yonge St. Canary - Human Resources, Employee File Pink - Employee

Definitions

"dependent" refers to a spouse or child as defined below.

"spouse" means:

1. a spouse of the employee through legal marriage

OR

2. a common law spouse of the employee

   a) with whom the employee has continuously resided for at least one year immediately prior to benefits coverage taking effect; and

   b) whom the employee has publicly represented as the only spouse during that one year period.

OR

3. a same-sex spouse of the employee

   a) with whom the employee has continuously resided for at least one year immediately prior to benefits coverage taking effect; and

   b) whom the employee has publicly represented as the only spouse during that one year period

Note: Coverage will not be applied retroactively. The Commission does not provide coverage for more than one spouse during any given period. The employee is responsible for notifying the Commission as to the identity of the spouse to be eligible for benefits coverage. The one-year period referred to in 2a) and 3a) above starts to run after a former spouse has been removed as a dependent for the purpose of benefits coverage.

"child" means a person who meets all the following criteria:

1. is not permanently physically or mentally disabled AND:

   a) is a natural or adopted child of the employee/plan member or the spouse of the employee, or over whom the employee/plan member or the spouse of the employee has court-appointed legal guardianship or court-appointed legal custody;

   b) lives with the employee/plan member, unless residing elsewhere for the sole purpose of attending a recognized educational institution in which the child is enrolled on a full-time basis, or is a child to whom the employee/plan member is obligated to provide benefit coverage pursuant to a written separation agreement;

   c) is under the age of 21, or under 25 if a full-time student at a recognized educational institution;

   d) is not employed full-time and relies on the employee/plan member for financial support; and

   e) does not have a spouse, as defined above.

   Note: The Commission may require proof of relationship with a child prior to approving benefits coverage. Proof of the student's full-time enrollment in a recognized educational institution is required on or before the child's 21st birthday and every year to the age of 25 (by completing this form).

OR

2. is permanently physically or mentally disabled AND:

   a) is a natural or adopted child of the employee/plan member or the spouse of the employee, or over whom the employee/plan member or the spouse of the employee has court-appointed legal guardianship or court-appointed legal custody;

   b) lives with the employee/plan member or is a child to whom the employee/plan member is obligated to provide benefit coverage pursuant to a written separation agreement;

   c) is under the age of 21 or a full-time student under 25 at the time of the onset of the disability, and the disability has been continuous since that time;

   d) is incapable of self-support, and is not employed full-time and relies on the employee/plan member for financial support; and

   e) does not have a spouse, as defined above.

   Note: The Commission may require proof of relationship with a child/student prior to approving benefits coverage. The Commission requires medical proof of disability prior to approving benefits coverage.

Coverage under this plan requires that you and any dependent(s) listed must be a Resident of Canada as well as have OHIP coverage.