

1. Retiree Information				
First Name	Last Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth (DD/MM/YYYY)	
Address		City	Province	Postal Code
Phone	Email		Provincial Health Care Coverage in Place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group from which you retired <input type="checkbox"/> PS/GE SGEU (168851) <input type="checkbox"/> CUPE 600-3 (168852) <input type="checkbox"/> Out-Of-Scope (168854)			Member ID	

2. Dependent Information Change	
Coverage under this plan is for: <input type="checkbox"/> Single <input type="checkbox"/> 1 dependent <input type="checkbox"/> 2 or more dependents	Effective Date of Change (DD/MM/YYYY)
Reason: <input type="checkbox"/> Birth of Child <input type="checkbox"/> Marriage <input type="checkbox"/> Cohabitation <input type="checkbox"/> Divorce <input type="checkbox"/> Separated Do you have a Spousal Interpersonal Agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Dependent Information

Complete this section if you have eligible dependents.

Spouse Information ¹	Date of birth (DD/MM/YYYY)	Gender
last name first name middle initial		<input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other

Dependant Information	Date of Birth DD/MM/YYYY	Gender	Provincial Health Care Coverage in Place?	Dependent age 21 or over? ²	Disabled Dependent
last name first name middle initial		<input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
last name first name middle initial		<input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
last name first name middle initial		<input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
last name first name middle initial		<input type="checkbox"/> Male <input type="checkbox"/> Undisclosed <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹ If your spouse is common-law, please complete the following:
 I have been living with and representing the above as my spouse since _____ (DD/MM/YYYY). My common-law spouse and I are financially responsible for all our dependents claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

² For each dependent age 21 and over:

- in the case of a student dependent under age 26, please indicate the educational institution where the child is receiving full-time training:

- in the case of a dependent due to a developmental or physical disability, please attach the PEBA Retiree Over-Age Dependent Questionnaire form M6943(PEBARR).

