gpm group benefits

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MULTIPLE EMPLOYEE INFORMATION CHANGE FORM (A)

Employer form

Group No.

EMPLOYER STATEMENT

Group Name

CHANGE OR ADDITION OF BENEFIT COVERAGE

All changes **RECEIVED BEFORE THE 10TH OF THE CURRENT MONTH** will appear on the following month's invoice.

1 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

2 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

3 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

4 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

5 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

6 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

7 Participant's Family Name(s) / Participant's Given Name(s) | GPM User ID | Code* | Effective Date of Change

New Annual Salary | Pertinent Information

*CHANGE CODES

Termination (End of Employement)	A	Change of Class / Category	C	Beginning of Absence (Disability/Sickness/CSST/SAAQ)	LDW
Re-integration of Employee	R	Maternity or Parental Leave	M	Leave of Absence	LOA
Temporary Lay Off	TLO	Change of Address	AD	Return to Work (Disability/Sickness /CSST/SAAQ)	RTW
Salary Change (Annual Basis)	S				

DECLARATION AND AUTHORIZATION

I understand that my coverage and that of my dependents, under the group insurance plan are conditional upon my dependents and I maintaining full coverage under the Public Health Care Insurance Plan in our province of residence. I certify that the above information is accurate and true. I understand that false, incomplete or inaccurate information may result in the rejection of any claim, or even the termination of part or all of my coverage through the Group Plan. I authorize GPM, its agents, representatives and service providers to collect, use, share, retain and disclose the information collected on this form and any information relating to my enrolment form regarding my dependents or myself, for the purposes of management, selection, verification or claims processing. I authorize my employer to deduct from my salary any contributions, if necessary, relating to my coverage through the group plan.

EMPLOYER'S SIGNATURE | Date (d/m/yyyy)