HMR
EMPLOYEE BENEFITS LTD.

Employee Change Card

A & W REGIONAL FRANCHISE ASSOCIATION

Employee's Surname | First Name | Middle Initial | Social Insurance Number | Gender ☐ Male ☐ Female | Birthdate YY MM DD | Policy Contract Number

Registered Name of Employer | Effective Date of Employee Change

EMPLOYEE CHANGE: CHECK REQUIREMENT AND PROVIDE REQUESTED INFORMATION

Restaurant Location Change

Change: ☐ Name ☐ Address ☐ Salary ☐ Class ☐ Coverage ☐ Location ☐ Terminate Employee

Employee Former Name
Complete for Change of Name

Reason for Change
Complete for Change of Coverage ☐ Single ☐ Family

Reason for Termination
Complete for Employee Termination

Employee Address

New Earnings
Complete for Change of Salary $ Hr Wk Bi Wk Mo Yr

Average Number of Hours Worked per Week

Complete for Change of Class New Class

City

Prov. ___ Postal Code

DEPENDENT CHANGE: CHECK REQUIREMENTS AND PROVIDE REQUESTED INFORMATION

Change: ☐ Add ☐ Terminate

If Adding Spouse, Check One and Enter Date
☐ Date of Marriage
☐ Date of Cohabitation
YY MM DD

If Spouse Previously Covered, Show Name of Insurance Company and Benefits Covered

Group Number and Previous Coverage

Termination Date of Previous Coverage YY MM DD

In this column:
1) If adding student age 21 or over, indicate name of School/University.
2) If dependent child is handicapped, please indicate nature of handicap.
3) If adding adopted child or ward, provide date you legally became the child's guardian.
4) If deleting dependent(s), give reason.
5) If changing dependent's name, indicate former name.

First Name	Initial	Surname	Gender M/F	Birthdate YY MM DD	Termination Date YY MM DD

I hereby agree that all statements and answers included in this application are true and complete

Signature of Employer | Signature of Employee | Date Signed

Please TYPE or PRINT clearly in ink

Please complete and return by Fax or Mail to:

HMR EMPLOYEE BENEFITS LTD.
220-2186 Oak Bay Ave.
Victoria, BC
V8R 1G3
Tel: (250) 592-4614
Toll Free: 1-888-592-4614
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