



PART 1 | PLAN INFORMATION

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| PLAN SPONSOR/GROUP NAME | |
| GROUP NUMBER | |
| DIVISION NUMBER | |
| PLAN ADMINISTRATOR (please print) | |

PART 2 | PLAN MEMBER INFORMATION

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|---|--|------------------------------------|--|---|
| PLAN MEMBER NAME (Last Name, First Name) | | | | |
| MEMBER ID # | | COVERAGE STATUS (Family/Single) | | EFFECTIVE DATE OF CHANGE (mm/dd/yyyy) |

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|---|--|------------------------------------|--|---|
| PLAN MEMBER NAME (Last Name, First Name) | | | | |
| MEMBER ID # | | COVERAGE STATUS (Family/Single) | | EFFECTIVE DATE OF CHANGE (mm/dd/yyyy) |

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|---|--|------------------------------------|--|---|
| PLAN MEMBER NAME (Last Name, First Name) | | | | |
| MEMBER ID # | | COVERAGE STATUS (Family/Single) | | EFFECTIVE DATE OF CHANGE (mm/dd/yyyy) |

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|---|--|------------------------------------|--|---|
| PLAN MEMBER NAME (Last Name, First Name) | | | | |
| MEMBER ID # | | COVERAGE STATUS (Family/Single) | | EFFECTIVE DATE OF CHANGE (mm/dd/yyyy) |

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|--------------------------------|--------------------------|
| PLAN ADMINISTRATOR'S SIGNATURE | DATE SIGNED (mm/dd/yyyy) |
| | |

Please complete this form and send a copy to Alberta Benefits Ltd. via email or by fax to 780.944.9168. Retain a copy for your files.

Alberta Benefits Ltd., #202, 10235-124th Street NW, Edmonton, Alberta, T5N 1P9, Canada
TEL: (780) 944 9167, FAX: (780) 944 9168, TOLL FREE: (866) 944 9167, www.albertabenefits.com