Employer Change Form

Adminplex Resource Services Inc.
30 Kelfield Street, Toronto, ON M9W 5A2
1.800.565.2467
Fax: 289.304.9052
V. 1.2

Clear form and start again

Employee's Name:	
Policyholder (Employer Name):	
Policy Number:	Certificate Number:

Transfer:	
Effective Date of the Transfer (mm/dd/yyyy):	
From:	**To:**
Division Number:	Division Number:
Class Number:	Class Number:
Department Number:	Department Number:

*** please note that if the employee is transferring from a Life Only class to a class with Health and/or Dental benefits, a new enrollment form must be filled out.**

Employment Information Changes:		
Effective Date of the Change (mm/dd/yyyy):		
Salary Basis: [Clear]	☐ hourly	☐ annually
Salary: $		
Hours per Week:		
Occupation/Title:		

Termination of Benefits:		
Effective Date of Termination (mm/dd/yyyy):		
Reason:	☐	No Longer Employed
	☐	No Longer Qualifies Based on Hours Worked
	☐	Transferred to a Different Facility
[Clear Checkboxes]	☐	Other: _____

If any changes need to be made to the employee's benefits, such as adding dependents to the plan, beneficiary changes, address changes, etc. please have the employee fill out an Employee Benefit Change Form, and send it to the address on the form.

Click to Save, Print then Sign and Return

_____
Date Signed (mm/dd/yyyy)