

## DAILY ACTIVITY REPORT

Please complete this report *immediately*, if any activity, and **fax it to us** at (519) 747-5323.

Policy Number: \_\_\_\_\_

Identifier/Billing Division: \_\_\_\_\_

Employer: \_\_\_\_\_

### NEW EMPLOYEES\* (and REHIRED/REINSTATED EMPLOYEES\*)

\*NOTE: A Group Insurance Enrollment Card and a Drug Card Enrollment Form must be completed.

Employee Name	Date of Full-Time Employment (or Date of Rehire/Reinstatement)

### CHANGES TO EMPLOYEES' COVERAGE

(salary changes, position changes, change in dependent status\*)

\*NOTE: A Drug Card Enrollment Form must also be completed if there is an addition of a dependent.

Employee Name	Date of Change	New Salary, Dependent Status, etc.

### EMPLOYEE TERMINATIONS

Employee Name and Home Address	Date of Termination of Full-Time Employment-i.e. last day worked

Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_