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IMAX SOLUTIONS

Employee Change / Termination / Re Hire Form

Plan Sponsor Name: _____ **Contract#:** _____

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Employee First Name		Last Name		Middle Name	
☐ **Terminate** ☐ **Re Hire**		Effective Date _____ mm-dd-yy		**Employee#**	

Please only fill in the sections which has been changed for the employee

Last Name		Mailing Address					
City		Province		Postal Code		Marital Status	
Phone		Cell		Email			

Change/Terminate/Re Hire	Effective Date	First Name of Dependent	Last Name	Relationship
1. ☐ **Terminate** ☐ **Re Hire**	_____ mm-dd-yy			
☐ **Change**				
2. ☐ **Terminate** ☐ **Re Hire**	_____ mm-dd-yy			
☐ **Change**				

Add Dependents First Name	Last Name	Middle Name	Relationship	Date of Birth	Gender
1.				_____ mm-dd-yy	
2.				_____ mm-dd-yy	

COMPLETE IF CHILD(REN) OVER AGE 21

_____ (Dependent Name)
☐ is a full-time student attending a post-secondary Educational Facility
☐ is no longer a full-time student attending a post-secondary Educational Facility

_____ (Dependent Name)
☐ is a full-time student attending a post-secondary Educational Facility
☐ is no longer a full-time student attending a post-secondary Educational Facility

COMPLETE IF DEPENDENT IS PARENT OR DISABLED ADULT CHILD

Do you currently claim your parent(s) or disabled adult child as dependent(s) on your income tax return? ☐ Yes ☐ No
If yes, you may add your parent(s) or disabled adult child as dependent.

THIS SECTION TO BE COMPLETED BY PLAN SPONSOR (TO BE FILLED IN FOR CHANGES ONLY)

Code New Employee Classification	New Annual Limit With Dependents	New Annual Limit Without Dependents

Codes: **1**. Owner **2**. Senior Management **3**. Full-time Employee **4**. Part-time Employee **5**. Hourly **6**. Other (specify)

I, an authorized representative of the plan sponsor, hereby confirm that the above named employee is eligible under the terms of the employee health care plan and that the employee is entitled to be reimbursed for eligible medical expenses as herein described. The undersigned agrees to notify Imax of any changes to the plan initiated by the plan sponsor.

For the added dependent(s) above the **EFFECTIVE DATE** of the plan is: _____ mm _____ dd _____ yyyy

Plan Sponsor Signature: X_____ Today's Date _____