STARSEED
Medicinal Inc.

STARSEED MEDICINAL INC. P.O. Box 279, Bowmanville, Ontario L1C 3L1
1-844-756-7333 | Sfax 1-844-409-6686 | info@starseed.com | All Forms Available for Download at starseed.com

Change of Information (COI) Form

INSTRUCTIONS: Every once in a while your information may need to be updated.
While we try to make it as painless as possible, we unfortunately need a written request to update your files.

If you need to change any of the information originally submitted on your Registration Application, please complete this Change of Information (COI) Form and send the signed document back to us by mail, fax, or email.

Starseed would be pleased to arrange for collection of this form or to provide you with a self-addressed prepaid envelope upon request.

If you have any questions, please don't hesitate to get in touch.

PART A: YOU MUST COMPLETE THIS SECTION

Client Name _____ _____
Last Name First Name

Client Registration Number: _____

PART B: PLEASE PROVIDE ONLY THE INFORMATION YOU WISH TO CHANGE IN THE SPACES BELOW:

APPLICANT INFORMATION

You must provide proof of any changes to your name, gender or date of birth

Name _____ _____
Last Name First Name

Date of Birth _____ ☐ Male ☐ Female ☐ Other
MMM/DD/YYYY

LIUNA INFORMATION

NOTE: LiUNA Members Only. Ensure to select the appropriate box to confirm your status with the union.

Insurance Company _____ **Group Policy Number** _____

Cert/Member # _____ **LiUNA Local** _____

☐ Active Member ☐ Active Dependant ☐ Retiree Member ☐ Retiree Dependant

CONTACT ADDRESS

NOTE: If the applicant is without a permanent address and receives services from an institution, please complete the Institution section below.

Address 1 _____

Address 2 _____

City _____ **Province** _____ **Postal Code** _____

Telephone _____ **Fax** _____ **Email** _____

I would like you to leave a message on my voicemail if I am not home: ☐ Yes ☐ No

Is your 'Mailing Address' the same as your 'Contact Address'? ☐ Yes ☐ No

Is your 'Shipping Address' the same as your 'Contact Address'? ☐ Yes ☐ No

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MAILING ADDRESS (IF DIFFERENT FROM CONTACT ADDRESS)

Address 1

Address 2

City **Province** **Postal Code**

SHIPPING ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)

Address 1

Address 2

City **Province** **Postal Code**

INSTITUTION WHICH PROVIDES SERVICES TO THE APPLICANT (IF APPLICABLE)

Address 1

Address 2

City **Province** **Postal Code**

Telephone **Fax** **Email**

Establishment Name (if applicable)

Establishment Type (if applicable)

To be completed by a manager of the specified institution that provides services to the applicant:

I _____ (Manager's Name), confirm that _____ (Establishment Name)

provides food, lodging or other social services to _____ (Applicant's Name)

Manager's Signature **Date**

AUTHORIZATION OF APPLICANT AND/OR RESPONSIBLE INDIVIDUALS

Please indicate if you are the applicant or a caregiver who is responsible for the applicant:

☉ Applicant ☐ Responsible Individual* ☐ Other Responsible Individual

Applicant Signature **Date**

MMM / DD / YYYY