

Change Form



COMPLETE THIS FORM TO NOTIFY OF A CHANGE

- Sections 1 and 3 – 7 to be completed by Plan Sponsor/Employer in ink.
- Sections 2 and 8 – 13 to be completed by Plan Member/Employee in ink.
- Section 14 to be signed by Plan Member/Employee and Plan Administrator in ink.
- Sections 3 – 13, please complete only the section that relate to your change.
- Return the ORIGINAL to the Plan Sponsor/Employer; make copy for your records. Plan Sponsor/Employer to maintain ORIGINAL in Employee file.
- **Complete and return to your employer within 31 days of the effective date of the change. If not, you and your dependents may be required to provide proof of insurability, and your benefits may be limited or denied.**

1 Plan Sponsor/Employer Information			
Client Name	Client/division code	Class	Insurance company name(s)
Policy/group contract numbers	Cost centre (if applicable)	Effective date of change	

2 Plan Member/Employee Information				
Last name	First name	Middle initial	Marital Status	Plan member ID#

3 Employment Status Change			
Current employment status			Hours worked/week
<input type="radio"/> Full-time	<input type="radio"/> Part-time	<input type="radio"/> Seasonal/contract	<input type="radio"/> Terminated
Effective:			
New employment status			Hours worked/week
<input type="radio"/> Full-time	<input type="radio"/> Part-time	<input type="radio"/> Seasonal/contract	<input type="radio"/> Terminated
Effective:			

4 Salary Change	
Current annual salary	New annual salary

5 Division Transfer	
Current division	New division

6 Class Change	
Current Class	New class

7 Cost Centre Change	
Current cost centre	New cost centre

8 Name Change			
<input type="radio"/> Employee	Current last name	Current first name	Current middle initial
<input type="radio"/> Spouse	New last name	New first name	New middle initial
<input type="radio"/> Dependent	Current last name	Current first name	Current middle initial

9 Address Change					
Current mailing address			New mailing address		
City	Province	Postal Code	City	Province	Postal Code

10 Coverage Change					
Health			Dental		
<input type="radio"/> Single	<input type="radio"/> Couple	<input type="radio"/> Family	<input type="radio"/> Single	<input type="radio"/> Couple	<input type="radio"/> Family

11 Birth Date Correction	
<input type="radio"/> Employee	Current birth date
<input type="radio"/> Spouse	New birth date
<input type="radio"/> Dependent	

12 Beneficiary Change

If you designate a beneficiary who is:
 (a) under the age of majority, or
 (b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

Original beneficiary information will be kept by your plan sponsor/employer.

Name of Beneficiary (last/first/middle)	Relationship to Plan Member	Beneficiary Revocable? **	Percent Allocate
		<input type="radio"/> Yes <input type="radio"/> No	%
		<input type="radio"/> Yes <input type="radio"/> No	%
		<input type="radio"/> Yes <input type="radio"/> No	%
		<input type="radio"/> Yes <input type="radio"/> No	%
Total value must equal 100%			Total %

I appoint _____ as trustee to receive any amount designated to a beneficiary who is under the age of majority or mentally incapacitated.

In the event the primary beneficiary or beneficiaries predeceases the plan member, the following contingent beneficiary or beneficiaries shall be entitled to the benefits:

Name of Contingent Beneficiary (last/first/middle)	Relationship to Plan Member	Beneficiary Revocable? **	Percent Allocated
		<input type="radio"/> Yes <input type="radio"/> No	%
		<input type="radio"/> Yes <input type="radio"/> No	%

13 Add or Delete a Dependent

Add Delete

Spouse's full name (last, first)	Birth date	Gender <input type="radio"/> M <input type="radio"/> F	Cohabitation Date
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Add Delete

Child's full name (last, first)	Birth date	Gender <input type="radio"/> M <input type="radio"/> F	Student <input type="radio"/> Yes <input type="radio"/> No
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Add Delete

Child's full name (last, first)	Birth date	Gender <input type="radio"/> M <input type="radio"/> F	Student <input type="radio"/> Yes <input type="radio"/> No
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Reason for Addition or Deletion:

14 Plan Member/Employee Declaration

I consent to the collection, use, and exchange of my personal information by my plan sponsor/employer or the administrator, an insurance company, and/or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependent children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to share information as it relates to the plan.

I hereby apply for group benefits under my plan sponsor's/employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my plan sponsor/employer.

I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time.

Plan Member/Employee signature

Date signed

Plan administrator signature

Date signed