Beneplan Inc

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Group Benefits CHANGE Form

Employee

Employer:		**Division:**	**Class:**	**Certificate:**
Last name:	**First name:**			**Coverage:** ☐ Single ☐ Family ☐ Opt Out
Effective date: (yyyy/mm/dd)	**Reason for change:**			

Spouse / Common Law

Action: ☐ Add ☐ Delete	**Last name:**	**First name:**	**Birth date:** (yyyy/mm/dd)	**Gender:** ☐ Male ☐ Female

Note: If common law, cohabitation started on: (yyyy/mm/dd) _____ / ___ / ___.

Children

Action:	**Last name:**	**First name:**	**Birth date:** (yyyy/mm/dd)	**Gender:**	
☐ Add ☐ Delete				☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
☐ Add ☐ Delete				☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
☐ Add ☐ Delete				☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
☐ Add ☐ Delete				☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
☐ Add ☐ Delete				☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped
☐ Add ☐ Delete				☐ Male ☐ Female	☐ Student age 21-24 ☐ Handicapped

Note: Children, age 21 to 24 must be full-time students to have coverage. Please complete "Student Eligibility" form.

Beneficiary

Last name:	**First name:**	**Relationship:**

Note: I appoint as revocable beneficiary of all the insurance payable in the event of my death. In the event that the named is a minor, I hereby appoint as trustee: (name) ____, (relationship to employee) ______________________________.

Opt Out

I declare that my spouse has acquired coverage through his/her employer and I wish to opt out of the benefits below. I understand that I may rejoin if my spouse loses his/her coverage. I further understand that to rejoin unconditionally, I must do so within 30 days of losing coverage, otherwise I will be required to provide evidence of satisfactory health and be subjected to approval.

☐ Health
☐ Dental

Spouse's insurance company and policy:

Co-ordination of Benefits (COB)

I declare that my spouse has acquired coverage through his/her employer and have indicated the type of coverage that applies.

☐ Health for spouse only
☐ Dental for spouse only
☐ Health for spouse and dependant(s)
☐ Dental for spouse and dependant(s)

Spouse's insurance company and policy:

Declaration

I declare that the information provided here is true, complete and accurate. A copy of this authorization shall be considered as valid as the original.

Employee signature: **Dated:** (yyyy/mm/dd)

Employer signature: **Dated:** (yyyy/mm/dd)