beneplan

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Group Benefits CHANGE Form

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