



Group #	Division #	Class	Certificate #	Name of Policyholder	Employee – Surname, First Name
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In order to process your change information, card must be dated and signed

STATUS CHANGE DESIRED [] Single to Family [] Family to Single [] No Change [] Nil to Single [] Nil to Family

* If you and/or your dependents are electing to waive health and/or dental coverage please complete the opt-out section below

CHANGE DUE TO:

- Marriage (date of marriage) _____ complete dependent information below
- Birth of Child - complete dependent information below
- Common-law spouse (date relationship commenced) _____ complete dependent information below
- Children of Common-law Spouse complete dependent information below
Do the children reside with you Yes No
- Separation (date of separation) _____
Are children still to be covered under your policy? Yes No
Is spouse still to be covered under your policy? Yes No
Are you legally obligated to provide these benefits? Yes No
If yes, please provide copy of legal agreement
- Divorce (date of separation) _____
Are children still to be covered under your policy? Yes No
Is spouse still to be covered under your policy? Yes No
Are you legally obligated to provide these benefits? Yes No
If yes, please provide copy of legal agreement
- Death of Dependent (date of death) _____
Relationship to Employee _____

PREVIOUSLY WAIVED BENEFITS

CHANGE DESIRED: [] Nil to Family [] Nil to Single [] Single to Family ** Please list all eligible dependents below
APPLICABLE BENEFITS: [] Health [] Dental

- I hereby apply to participate in the Health and/or Dental benefits that were previously refused due to the existence of comparable coverage.
My comparable coverage terminated on _____ Previous Insurance Carrier _____
- I wish to duplicate the coverage my spouse currently has

ELIGIBLE DEPENDENT INFORMATION

Dependents must be insured under a provincial government health plan and domiciled in Canada.

Name (indicate surname if different than employee's)	Date of Birth (yy/mm/dd)
Spouse _____	_____
Children _____	_____
_____	_____
_____	_____

If child(ren) are over 21 (and under 25) please complete the following:

Does he/she attend college/university full time?
 Yes No

If "Yes", please provide proof of full-time registration such as a Registrar's or tuition receipt including dates of attendance

Name of School _____

Does he/she work? Yes No Hrs per week _____

BENEFICIARY CHANGE ensure that the bottom of this application is dated and signed

I hereby designate the following beneficiary under the certificate and revoke the appointment of any existing beneficiary. I reserve the right, without the consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions.

Beneficiary _____ Relationship to Insured _____
(full legal name)

Witness _____ Trustee _____
(must be legal age and someone other than the beneficiary) (a trustee must be appointed if beneficiary is under 18 years of age)

NAME CHANGE ensure that the bottom of this application is dated and signed

Employee's New Last Name _____ First Name _____ Middle Name _____

WAIVE BENEFITS / OPT-OUT

CHANGE DESIRED: [] Family to Single [] Family to Exempt [] Single to Exempt

I hereby certify that I have been given the opportunity to participate in my employer's insurance plan. Comparable coverage is currently provided to me and/or my dependents under another group plan. Because of these existing benefits I am declining coverage as indicated: Check either column A or B, but not both.

A – Employee and Dependent(s) Health Dental B – Dependent(s) only Health Dental

My spouse is employed by _____ Insured by (carrier) _____

Coverage commenced on (date) _____

I understand that, if I cease to be covered under my spouse's plan and I wish to participate in the benefits hereby declined, I will have to complete an Application for Benefits Previously Waived within 31 days of loss of coverage. If application is not made within 31 days I will have to furnish evidence of insurability satisfactory to the Insurance Company at my own expense. Where dental coverage is in place, there will be a dental restriction of \$250 per individual for the first year of coverage.

Authorization: I understand the information I provide on this form will be used to determine my eligibility for group insurance and to administer my benefits under this plan. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or revoked in writing by myself.

Date _____ Signature of Employee (in ink) X