



MEMBER CHANGE REQUEST

Member: Please print clearly, complete all applicable sections of this form and sign section 11. Pass this form onto your Plan Administrator after you have completed it.

Plan Administrator: Please review and sign this form prior to submitting to Sirius Benefit Plans.

1	Group #:		Firm #:		Firm Name:	
	Certificate #:			Member Name:		

2	Member Address Change	New Address	Effective Date DD / MM / YYYY
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3	Member Name Change	Old Name	Last	First	Reason for Change
		New Name	Last	First	Effective date of Change DD / MM / YYYY

4	Marital Status Update	Change status to:	<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> common-law	Date change occurred DD / MM / YYYY
				date of co-habitation: DD / MM / YYYY

5	Class Change	Change Class to:	Reason for change:	Date change occurred DD / MM / YYYY
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6	Addition of Benefits If choosing to add coverage for dependents, you must list all dependents under #8	Extended Health Care (EHC) I wish to add EHC coverage for: <input type="checkbox"/> myself <input type="checkbox"/> myself and my dependents	Dental Care I wish to add Dental coverage for: <input type="checkbox"/> myself <input type="checkbox"/> myself and my dependents	Dependent Life <input type="checkbox"/> I wish to add Dependent Life coverage
		Reason for addition of coverage: (i.e. If you lost coverage under a spouse's plan you must provide an explanation and indicate the date the coverage ceased).		

7	Refusal of Benefits You may only refuse EHC and/or Dental coverage if you and/or your dependents are covered for similar benefits under a spouse's plan	Extended Health Care (EHC) I do NOT want EHC coverage for: <input type="checkbox"/> myself and my dependents <input type="checkbox"/> my dependents only	Dental Care I do NOT want Dental coverage for: <input type="checkbox"/> myself and my dependents <input type="checkbox"/> my dependents only
		Date coverage began under spouse's plan DD / MM / YYYY	Date coverage began under spouse's plan DD / MM / YYYY

8	Termination of all dependent coverage This only applies if you no longer have dependents (spouse or children)	<input type="checkbox"/> I wish to terminate all coverage for all dependents <input type="checkbox"/> I wish to terminate coverage for some of my dependents (must complete #8)	Effective date of termination DD / MM / YYYY	Reason for termination
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9	Dependent Information		Please complete this section when changing information on existing dependents or adding /removing a dependent. Ensure that you include your spouse when listing your dependents.						
	Change type code (see below)	Effective date of change DD/MM/YYYY	Name		Date of Birth DD/MM/YYYY	Sex M or F	Relationship	For over-age dependent children only see booklet for definitions of each	
			Last	First				Full-time University or College Student?*	Disabled Dependent*
								Yes or No	Yes or No?
Change type codes: A=add, C= change D= delete		*Please complete an overage dependent application if the dependent child is attending college or university (secondary education) or if you wish to submit your dependent child as an overage disabled dependent. Your booklet contains additional information.							

10	Beneficiary Change Note: The effective date of the Beneficiary change is the date this form is signed.	I hereby revoke all prior beneficiary designations and now designate the person(s) named as my revocable beneficiary. For Quebec residents only: The beneficiary is considered irrevocable unless you check here <input type="checkbox"/> , which then identifies that the beneficiary is revocable.			
		Name		Relationship to Member	Percentage (cannot exceed 100% in total)
		Last	First & Middle Initial		
Trustee Designation		I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.			
This section is to be completed only if the beneficiary designated above is under the age of majority					

11	I acknowledge that the information provided is true and accurate. If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purpose of determining eligibility for benefits.		
	Member Signature	Date Signed	DD / MM / YYYY

12	Member Termination	Reason for termination:	Last day worked
		<input type="checkbox"/> no longer employed <input type="checkbox"/> laid-off	DD / MM / YYYY

13	Plan Administrator Signature	Date Signed	DD / MM / YYYY

All changes are subject to the terms of the Group Contract(s) and any applicable legislation.