Benefit plans administered by: **D.A.Townley** 4250 Canada Way, Burnaby, BC V5G 4W6 www.datownley.com

EMPLOYER NAME: _____
POLICY #: _____

GROUP INSURANCE CHANGE FORM

Please complete in ink and print clearly. Please fill in all information and ensure you have signed and dated this form.

EMPLOYEE INFORMATION

EMPLOYEE SURNAME	FIRST	INITIAL	SOCIAL INSURANCE NUMBER/ I.D. NUMBER	IS THIS A NAME CHANGE? ☐YES ☐NO

ADDITION or DELETION OF DEPENDENTS or DEPENDENT NAME CHANGE

INDICATE: **A** (Add Dependent) **D** (Delete Dependent) **N** (Name Change)	DEPENDENT'S SURNAME	FIRST NAME	INITIAL	RELATIONSHIP TO EMPLOYEE (Spouse/ Son/ Daughter)	DATE OF BIRTH Yr/Mo/Day	STUDENT (Yes/No) and name of School, if over 21	EFFECTIVE DATE OF ADDITION OR DELETION
☐A ☐D ☐N							
☐A ☐D ☐N							
☐A ☐D ☐N							

If adding a spouse, indicate:
DATE OF MARRIAGE (OR DATE OF COMMENCEMENT OF COMMON-LAW RELATIONSHIP): _____
common-law spouses and their children may be eligible with a minimum co-habitation period as indicated in your group policy. NOTE: Only the children of your common-law spouse who are residing with you are considered eligible dependents.

CO-ORDINATION OF BENEFITS

Are you covered by another benefit plan (ie your Spouse's plan)? YES ☐ NO ☐ If YES, indicate the benefits covered:

Benefits _____ Policy No(s)_____ Insurance Carrier _____

REVISED GROUP LIFE INSURANCE BENEFICIARY DESIGNATION

I designate the following individual(s)* as my revocable group life insurance beneficiary(ies), if living, otherwise my Estate* and revoke any prior designation I have made. *Indicate Estate, if no named beneficiary.

Life Insurance			**Optional Life Insurance (if applicable)**		
NAME (Surname, First Name & Initials)	RELATIONSHIP		NAME (Surname, First Name & Initials)	RELATIONSHIP	
		%			%
		%			%
		%			%

TRUSTEE CLAUSE: If appointing a minor beneficiary, complete the following (Trustee must be of legal age):

I designate the following trustee to receive and disburse any monies payable under this group policy to my beneficiary(ies) during minority, and any payments made to this trustee will release the insurer of any further liability:

_____ _____
Trustee's Full Name Relationship to Employee

GROUP BENEFIT CHANGES

☐ APPLICATION FOR: ☐ DELETION OF:
☐ Dental
☐ Extended Health (may include Vision Care)
☐ Other (specify)_____
☐ Myself and/or ☐ My dependents

REASON FOR ADDITION OF BENEFITS OR DELETION OF BENEFITS

☐ Comparable coverage has been provided under my Spouse's plan. This alternate coverage ceased: _____/_____/_____ (YY/MM/DD)

☐ Late Application: Coverage was previously waived as it was optional and I did not wish to participate. Coverage is now requested. I have included the required evidence of insurability forms. I understand that the insurance company must approve my application and advise me of the effective date. I also understand that some benefit limitations may apply.

☐ Comparable coverage is provided under my Spouse's plan. This alternate coverage is effective: _____/_____/_____ (YY/MM/DD)

☐ If coverage is optional, I do not wish to participate.
I agree that if at a later date I wish to participate in the insurance hereby refused, I must submit, at my own expense, evidence of insurability for myself and any dependents for whom application for coverage is made. However, if I have refused Health/Dental Insurance because of other group coverage, such evidence of insurability will not be required provided the alternate coverage terminates and I apply for Health/Dental Insurance within 31 days of the termination date.

CONFIRMATION OF REVISIONS

I, the undersigned, hereby:

a) certify that the information provided on this form is correct,
b) consent to the collection, use and disclosure of my personal information by the Plan Administrator for the purpose of administering the Plan and the benefits that may be conferred on members of the Plan,
c) agree to be bound by all the terms and conditions of the Group Insurance Plan,
d) **agree to promptly update my Employer and the Plan Administrator on any changes to the status of a Spouse, dependent or beneficiary,** and agree that I am liable for any benefit paid out incorrectly in the event that I have not updated my Employer and the Plan Administrator on any change to the status of a Spouse, dependent or beneficiary,
e) understand that completion of this form does not in itself, entitle me to benefits – qualification for benefits is subject to the eligibility requirements of my employer's group insurance plan.

_____ _____
SIGNATURE OF EMPLOYEE **DATE**

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The collection, use and disclosure of an individual's personal information, during his/her participation in the Plan is for the purpose of administering the Plan and the benefits that are conferred on members of the Plan. The collection, use and disclosure of personal information about individual members of the Plan will be done in a manner that is reasonable. Furthermore, reasonable security arrangements will be taken to prevent any unauthorized access, collection, use, disclosure, copying, modification or disposal of personal information about individual members of the Plan.