

PLEASE PRINT IN BLOCK LETTERS

Received:		Processed:	
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For Office Use Only

1 Intention of Form - Select All That Apply

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> New Hire / Rehire / Re-instatement | <input type="checkbox"/> Change in Employee Address | <input type="checkbox"/> Change Benefit Coverage | <input type="checkbox"/> Change Legal Name |
| <input type="checkbox"/> Change in Marital Status | <input type="checkbox"/> Add or Remove a Dependent | <input type="checkbox"/> Change Beneficiary(ies) | <input type="checkbox"/> Other: Please Indicate |

Other Change Reason: _____

2 Plan Sponsor / Employer Information

Your employer must complete this section.

Client Name _____		Client Division/Code _____	Class _____	Cost Centre _____
Employee Member ID _____	Employee Hire/Rehire Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Occupation _____		
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree	Annual Salary _____	Hours Per Week _____	<input type="checkbox"/> Yes - Waiver of Waiting Period Form Attached	<input type="checkbox"/> No

3 Plan Member / Employee Information

You must complete this section for every change.

Last Name _____	First Name _____	Initials _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Common-Law	Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Gender _____ Province of Residence _____

4 Plan Member / Employee Mailing Address

Complete on New Hire, or to Indicate New Mailing Address

Address _____				
City/Town _____	Province _____	Country _____	Postal/Zip Code _____	Effective Date (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

5 Change Marital Status or Legal Name

Complete to Change Marital Status and/or Legal Name of the Plan Member / Employee or a Dependent

<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Common-Law	Effective Date of New Marital Status <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse / Common-Law Partner <input type="checkbox"/> Other Dependent	Effective Date of New Legal Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Last Name _____	First Name _____	Initials _____

6 Plan Member / Employee Dependents

Complete on New Hire, or to Add or Remove Dependents

To be eligible for benefits coverage, your dependent children are required to be unmarried, under age 18, or under age 25 if they are a full-time student at a recognized school and dependent on you for financial support. Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting ages above, and are completely dependent on you for financial support. Eligible dependents may vary depending on the benefit plan. Check with your Plan Sponsor/Employer for further information.

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Effective Date (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Marriage / Separation / Divorce <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Gain/Loss of Spousal Benefits <input type="checkbox"/> Death <input type="checkbox"/> Other	Reason for Addition / Removal (if applicable) _____
Last Name _____	First Name _____	Initials _____	
Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Gender _____	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	Relationship to Plan Member / Employee _____

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Effective Date (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Marriage / Separation / Divorce <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Gain/Loss of Spousal Benefits <input type="checkbox"/> Death <input type="checkbox"/> Other	Reason for Addition / Removal (if applicable) _____
Last Name _____	First Name _____	Initials _____	
Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Gender _____	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	Relationship to Plan Member / Employee _____

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Effective Date (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Marriage / Separation / Divorce <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Gain/Loss of Spousal Benefits <input type="checkbox"/> Death <input type="checkbox"/> Other	Reason for Addition / Removal (if applicable) _____
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