

## EMPLOYEE CHANGE REQUEST

For office use only

Effective Date

Certificate #

### To be Completed by the Employer (Please print clearly in ink)

Firm/Company Name		Firm/Division #	
Employee First Name		Last Name	
Certificate #			
<input type="radio"/> Occupation Change	New Occupation		Effective Date (YYYY/MM/DD)
<input type="radio"/> Salary Change	Regular Earnings \$	Frequency	<input type="radio"/> Annually <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Bi-Weekly <input type="radio"/> Semi-Monthly <input type="radio"/> Hourly
			If hourly, # hours/week
<input type="radio"/> Transfer Division/Class	Old Division/Class	New Division/Class	Effective Date (YYYY/MM/DD)
<input type="radio"/> Terminate Employee's Coverage	<input type="radio"/> Employee Left Employment <input type="radio"/> Other Reason (please specify)		
Last Day of Work (YYYY/MM/DD)			
<input type="radio"/> Reinstate Employee's Coverage	Date of Return to Work (YYYY/MM/DD)		
Employer's Signature		Date	

### To be Completed by the Employee (Please print clearly in ink)

Check the changes you are making and provide ALL the information requested for EACH section you check.

<input type="radio"/> Address Change	New Address	
	Province or territory of Employment (if different)	
<input type="radio"/> Employee Name Change	From	Date of Change (YYYY/MM/DD)
	To	
	Reason for Change	
	Employee Email Address	
<input type="radio"/> New Marital Status (If checked, please see Dependent Status and New Beneficiary below)	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Divorced	Date (YYYY/MM/DD)
	<input type="radio"/> Common Law (Please provide date you began living together)	
<input type="radio"/> Add Benefits	<input type="radio"/> Health <input type="radio"/> Dental (Complete <i>Dependent Status</i> if requesting family coverage) Previously covered under another plan? <input type="radio"/> No <input type="radio"/> Yes, up to (YYYY/MM/DD)	
<b>Coordination of Benefits</b> <input type="radio"/> Cancel <input type="radio"/> Change Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.	<input type="radio"/> Health <input type="radio"/> Dental   Other Insurer's Name	Date of Change (YYYY/MM/DD)
	What group benefit coverage does your spouse have through their employer? Healthcare <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Waived <input type="radio"/> None Dental <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Waived <input type="radio"/> None	
<input type="radio"/> Dependent Status	<input type="radio"/> Change from family to single coverage Reason	Date of Change (YYYY/MM/DD)
	<input type="radio"/> Change from single to family coverage Reason	Date of Change (YYYY/MM/DD)

List all your dependents affected by the change, including your spouse: (Please print clearly in ink)

	Date of Change (YYYY/MM/DD)	Last Name	First Name	Relationship*	Birthdate (YYYY/MM/DD)	Gender Female /Male Other Expression/Undisclosed
<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Delete						
<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Delete						
<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Delete						

Coverage under your Provincial Health plan is necessary in order for you and your dependents to be eligible for Extended Health coverage.

**\*If a dependent is disabled, please complete the Request for Over-age Disabled Dependent Coverage form. If a dependent is an over-age dependent, please complete the Request for Over-age Dependent Coverage form. Please see your Plan Administrator for details.**

## Employee Signature (Please sign and date here)

### Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

I authorize Maximum Benefit and its insurers to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of [www.maximumbenefit.ca](http://www.maximumbenefit.ca) or from the administrator of my benefit program.

A photocopy or electronic version of this **Declaration and Authorization** is as valid as the original.

Employee's Name (please print) \_\_\_\_\_  
FIRST NAME LAST NAME

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE COMPLETE AND SIGN THIS SECTION IF YOU ARE CHANGING YOUR BENEFICIARY DESIGNATION.**

**Primary Beneficiary Designation** – Please print clearly in INK:

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.

**Divided:**  **In equal shares to survivor(s)** (Do not need to enter % of benefit)  **As per percentages below**

Last Name	First Name and Initial	% of Benefit (must total 100%)	Relationship to Employee	Date of Birth (YYYY/MM/DD)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here:  **Revocable**, I may change this designation at any time

**Trustee/Administrator Designation (must be over the age of majority)**

**If the beneficiary is under the age of majority (not applicable for QC residents)**, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

FIRST NAME

LAST NAME

RELATIONSHIP TO EMPLOYEE

*If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.*

**For Quebec Only:** The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

### Contingent Beneficiary Designation – OPTIONAL (Cannot be the same beneficiary as listed under *Primary Beneficiary*)

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Divided:  In equal shares to survivor(s) (Do not need to enter % of benefit)  As per percentages below

Last Name	First Name and Initial	% of Benefit (must total 100%)	Relationship to Employee	Date of Birth (YYYY/MM/DD)

### Trustee/Administrator Designation (must be over the age of majority)

If the beneficiary is under the age of majority (not applicable for QC residents), I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

\_\_\_\_\_

FIRST NAME LAST NAME RELATIONSHIP TO EMPLOYEE

If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.

**For Quebec Only:** The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

A photocopy or electronic version of this form is **not valid** for recording beneficiary designations.

Employee's Name (please print) \_\_\_\_\_

FIRST NAME LAST NAME

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

The original of this form must be submitted. Photocopies are not accepted. Please mail this completed form to the address below.