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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 Name				Certificate #
◯ **Occupation Change**	New Occupation			Effective Date (YYYY/MM/DD)
◯ **Salary Change**	Regular Earnings $	Frequency ◯ Annually ◯ Weekly ◯ Monthly ◯ Bi-Weekly ◯ Semi-Monthly ◯ Hourly		If hourly, # hours/week
◯ **Transfer Division/Class**	Old Division/Class	New Divison/Class		Effective Date (YYYY/MM/DD)
◯ **Terminate Employee's Coverage** Last Day of Work (YYYY/MM/DD)	◯ Employee Left Employment ◯ Other Reason (please specify)			
◯ **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.

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

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

	Date of Change (YYYY/MM/DD)	First and Last Name	Relationship*	Birthdate (YYYY/MM/DD)	Gender
◯ Add ◯ Change ◯ Delete					
◯ Add ◯ Change ◯ Delete					
◯ Add ◯ Change ◯ 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 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) _____

Employee's Signature _____ Date _____

CONTINUED

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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.

Full 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.

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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.

Full 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) _____

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.

MAXIMUM BENEFIT NATIONAL SERVICE CENTRE
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