Reset Form

Change of Record

the benefits trust

Effective date of change: m	d	y

Employer's Name	Group / Policy No.	Division No.	Dept. No.

Employee's Name (Please record your old name, if name change being requested)	Employee Certificate No. or SIN

CHANGE OF NAME (Please record new name. In addition, you must complete the "Reason for Change" section)

Last Name	First Name	Middle Initial

CHANGE OF ADDRESS

Address	Province	Postal Code

CHANGE OF STATUS

I wish to change my status to: Single ☐ Family ☐

If changing to "family", please complete the "Adding and/or Deleting a Dependant" section.

Name of Spouse	Spouse's birthdate m	d	y

If you should wish to apply for Optional Life Insurance on your spouse (if available), please complete the "Change in Optional Amounts of Coverage" section.

REASON FOR CHANGE OF NAME/STATUS

☐ Marriage Date: m_____d_____y_____

☐ Divorce/Separation: Date: m_____d_____y_____

☐ Common-law Date: m_____d_____y_____

☐ Spouse's plan terminated Date: m_____d_____y_____

☐ Court order

☐ Name given incorrect

WAIVING HEALTH AND/OR DENTAL BENEFITS

You may only waive health and/or dental coverage for you and/or your dependants if covered for similar benefits under your spouse's plan. If coverage is waived, you must provide us with the name of your spouse's employer and insurance company.

Health Benefit
- ☐ Single (I waive coverage on my dependants)
- ☐ Waived (I waive for myself and my dependants)

Dental Benefit
- ☐ Single (I waive coverage for my dependants)
- ☐ Waived (I waive for myself and my dependants)

Spouse's Employer: _____

Spouse's Insurer: _____

I understand that if I wish to request the coverage at a later date, I may be required to furnish, at my own expense, for myself (and for my eligible dependants, if applicable) evidence of insurability to The Benefits Trust.

ADDING AND/OR DELETING A DEPENDANT

		Last Name	First Name	M / F	Date of Birth (m/d/y)	Full Time Student	Disabled
	Spouse						
☐ Add ☐ Delete							
	Children						
☐ Add ☐ Delete						☐	☐
☐ Add ☐ Delete						☐	☐
☐ Add ☐ Delete						☐	☐

Is your spouse insured for Health and/or Dental under his/her employer's plan?

Health Benefit ☐ No ☐ Single ☐ Family

Dental Benefit ☐ No ☐ Single ☐ Family

Spouse's Employer: _____

Spouse's Insurer: _____

APPOINTMENT OR CHANGE OF REVOCABLE BENEFICIARY DESIGNATION

Last Name	First Name	Middle Initial	Relationship to Applicant:

FOR QUEBEC RESIDENTS: The appointment of a spouse as Beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is actually written after the spouse's name.

CHANGE IN OPTIONAL AMOUNT OF COVERAGE (In addition, please complete and submit Evidence of Insurability form)

Amount being requested (Contact your Plan Administrator regarding coverage amounts.)

Applicant: ☐ New ☐ Additional $ _____

Spouse: ☐ New ☐ Additional $ _____

If you are applying for Optional Life Insurance on your spouse, please fill in his/her name and birthdate in the "Change of Status" section.

TERMINATION OF OPTIONAL/VOLUNTARY AMOUNTS OF COVERAGE

Applicant:
☐ I wish to terminate my Optional Life Insurance

Spouse/Dependants
☐ I wish to terminate my Optional Life Insurance

CHANGE OF CLASS, EARNINGS, DEPARTMENT, DIVISION

☐ **Class:** From: _____ To: _____

☐ **Earnings:** From: _____ To: _____

☐ **Department:** From: _____ To: _____

☐ **Division:** From: _____ To: _____

_____ _____
Employee's Signature Date

_____ _____
Plan Administrator's Signature Date