Change of Record			benefits trust			
				Effective date of c	hange:	
Employer's Name			Group / Policy	/ No.	Division No.	Dept. No.
Employee's Name (Please record you	ur old name, if name char	nge being request	ted)	Employee Certifica	ite No. or SIN	
CHANGE OF NAME (Please recor	rd new name. In addit	ion, vou must c	complete the	"Reason for Char	ge" 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 a Dependant"		e complete the "Ad	ding and/or Dele	ting
Name of Spouse				Spouse's birthdate	e d	lv
If you should wish to apply for Optio Optional Amounts of Coverage" secti		ur spouse (if avail	able), please o		je in	_1/
REASON FOR CHANGE OF NAME	S/STATUS					
Marriage	Date: md	у		Court order		
Divorce/Separation:	Date: md	у		Name given incom	rect	
Common-law	Date: md	у				
Spouse's plan terminated	Date: md	у				
WAIVING HEALTH AND/OR DEN	NTAL BENEFITS					
You may only waive health and/or do your spouse's plan. If coverage is winsurance company.	ental coverage for you an				s under	
Health Benefit		ve coverage on maive for myself and		nts)		
Dental Benefit	Single (I waiv	ve coverage for make	ny dependants)			
Spouse's Employer:			Spouse's Insu	rer:		
I understand that if I wish to reques (and for my eligible dependants, if a	_			sh, at my own expe	nse, for myself	

ADDIN	G AND/OR DELE	TING A DEPENDA	ANT						
	Sno	Last Name ouse		First Name	М	/ F	Date of Birth (m/d/y)	Full Time Student	Disabled
	Add						(11/4/y)	Student	Disabled
	Delete								
_		dren							_
님	Add Delete								Ш
	Add Delete							Ш	Ш
	Add Delete							Ш	
	Delete								
Is your	spouse insured for	Heath and/or Dent	tal under his	s/her employer's pla	in?				
	Health Benefit	☐ No		Single			Family		
	Dental Benefit	□ No	П	Single		П	Family		
	Dental Benefit	LI NO		Sirigle		ш	ranniy		
Spouse's	s Employer:				Spou	use's 1	Insurer:		
				FICIARY DESIGNA			I=		
Last Na	me	Firs	t Name	N	Middle Initial		Relationship to Applicant:		
	EBEC RESIDENTS: lly written after the		of a spouse	e as Beneficiary is co	onsidered "IRREV	OCAB	LE" unless the word "REVOO	CABLE"	
is actual	ny written arter are	e spouse s name.							
						subm	it Evidence of Insurabili	ty form)	
Amount	being requested (Contact your Plan A	Administrato	r regarding coverag	je amounts.)				
App	licant:	New							
		Additional		\$					
Spo	use:	New							
		Additional		\$					
If you a	re applying for Op	tional Life Insuranc	e on your s	oouse, please fill in l	his/her name and	birth	date in the "Change of State	us" section.	
					_				
Applicar		IONAL/VOLUNTA	RY AMOU	NTS OF COVERAG		ıse/D	ependants		
		te my Optional Life	Insurance			200,2	I wish to terminate my Opt	ional Life Insurar	nce
					<u> </u>				
CHANG	E OF CLASS, EA	RNINGS, DEPART	MENT, DI	/ISION					
	Class:		From:				To		
	Class.						10.		
	Earnings:		From:				To:		
Ιп	Department:		From:				To:		
ш	Division:		From:				To:		
	Emplo	yee's Signature					Date		
Plan Administrator's Signature							Date		