SmartChoice BENEFITS

GROUP BENEFITS CHANGE FORM

Please PRINT clearly. Complete the form in **INK**, sign and date the form and return to your plan administrator for handling.

1 General Information

To be completed by plan administrator.

Only complete the information that is changing and include the effective date of the change

All changes must be submitted within ***31 days from the effective date of the change***

Name of employer

Group policy number | Account/Division number | Account/Division name

Last name of employee | Middle initial | First name

Date of birth (mm/dd/yyyy) | Plan member certificate Number | Effective date of change (mm/dd/yyyy)

2 Type of change requested

- ☐ Change Coverage/Dependent Information (Complete Sections 1, 3 and 8)
- ☐ Cancel Health and/or Dental Benefits (Complete Sections 1, 4 and 8)
- ☐ Add or Reinstate Health and/or Dental Benefits (Complete Sections 1, 5 and 8)
- ☐ Change Employees name or address (Complete Sections 1, 6 and 8)
- ☐ Change Beneficiary Designation (Complete Sections 1, 7 and 8)

3 Change in Coverage/ Dependent Information

This section to be completed if you are adding or deleting a dependent or updating dependent information

- ◯ Single Coverage
- ◯ Family Coverage (Complete Spousal and/or Dependent information)
- ◯ Opt Out (Complete Refusal of Health and/or Dental benefits Section 4)

Reason for change :

☐ Birth of child ☐ Divorce ☐ Marriage ☐ Common-Law — Date of Marriage/ Common-Law

☐ Widowed ☐ Separated ☐ Other (please specify) _____

Spousal Information

For common-law status you must have been cohabiting as defined by the plan contract provisions for dependent eligibility

Claims for a spouse must **first** be sent to his/her own employer's plan

Coordination of Benefits allows you to submit claims under one plan and submit any remaining unpaid amounts to the other insurance carrier.

Add	Change	Remove	Last name	First name	Date of birth (mm/dd/yyyy)	Sex
◯	◯	◯				◯ M ◯ F

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

◯ Yes ◯ No — Health Care ◯ Single ◯ Family — Dental Care ◯ Single ◯ Family — Effective date (mm/dd/yyyy)

Name of spouse's employer _____ Policy No. _____

Name of insurance Carrier _____ Certificate No. _____

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

◯ Remove Coordination of benefits: Effective (mm/dd/yyyy)

My Spouse/partner no longer has coverage for ☐ Health ☐ Dental benefits

Dependent Information

Claims for covered children must be sent to the plan of the parent whose birthday falls first in the calendar year

Add	Change	Remove	Last name	First name	Date of birth (mm/dd/yyyy)	Sex	Dependent Status
◯	◯	◯				◯ M ◯ F	◯ Student ◯ Disabled
◯	◯	◯				◯ M ◯ F	◯ Student ◯ Disabled
◯	◯	◯				◯ M ◯ F	◯ Student ◯ Disabled

* **Full-time student (College/University): Proof of school registration is required** prior to the beginning of each school year for a dependent child age 21 or over but under the age of 25.

For Quebec plan members, please check with your plan administrator for dependent student age limit.

** To enrol an over-age disabled child, you will need to complete a Disabled Child Coverage form, and send it to us within 31 days of the date the dependent reaches the age limit. Please see your plan administrator.

4 Refusal of Health and/or Dental Benefits

You must provide the name of your spouse's employer and insurance company in ***Section 3***.

If you or your dependents are currently covered for ***Health and Dental benefits*** under another plan, such as a spouse's plan, you may refuse to be covered for these benefits by selecting the applicable box below.

◯ I refuse Health care benefits ◯ For myself and my dependents ◯ My Dependents only

◯ I refuse Dental care benefits ◯ For myself and my dependents ◯ My Dependents only

If your spouse's coverage terminates, you must apply for health and dental benefits within 31 days from the date your spouse's coverage ends. If you do not apply within 31 days, you and/or your dependents may be required to provide satisfactory medical evidence for the insurance carrier's review. If you are approved, coverage for the dental benefits will be limited for the first year.

5 Addition of Group Health and/or Dental Benefits

You must provide the name of your spouse's employer and insurance company in ***Section 3***.

I am no longer covered under my spouse's group insurance plan; I hereby request addition of :

◯ Health care benefits ◯ For myself and my dependents ◯ For myself only

◯ Dental care benefits ◯ For myself and my dependents ◯ For myself only

Coverage for Health and/or Dental care benefits under my spouse's group insurance plan terminated on

Date (mm/dd/yyyy) _____ Reason for Termination _____

6 Employee Name/ Address Change

☐ Change name ☐ Change address

New last name _____ First name _____

Reason for change ◯ Marriage ◯ Divorce Date of Marriage/Divorce _____ ◯ Other _____

New mailing address _____ Postal code _____

City _____ Province _____ Telephone number _____

Email address _____

7 Primary Beneficiary Designation Change

The original of this form will be required for Life and/or Accidental Death claim

You must initial any changes or deletions. Correction fluid cannot be used.

Percentage must total 100% to be valid

By signing below I confirm that I am revoking all previous beneficiary designations and designate the following as beneficiary(ies):

Name of Beneficiary (first and Last name)	Relationship	Date of birth (mm/dd/yyyy)	Percentage

Where Quebec law applies, the designation of your spouse as beneficiary is considered irrevocable unless otherwise specified.

◯ Revocable ◯ Irrevocable

If the beneficiary is shown as irrevocable, his/her consent is required to change it.

Contingent Beneficiary

If there are no surviving primary beneficiaries at the time of your death, the contingent beneficiaries will be entitled to receive the proceeds. If there are no surviving contingent beneficiaries at the time of your death, the proceeds shall be paid to your estate.

Name of Contingent Beneficiary (first and Last name)	Relationship to employee	Date of birth (mm/dd/yyyy)	Percentage

Trustee Appointment

Complete this section if any beneficiary or contingent named is under the age of majority, as defined by provincial legislation.

Name of Trustee (first and Last name)

The trustee for a Contingent Beneficiary cannot be the Primary Beneficiary.

Note: In Quebec any amount payable to a beneficiary under the age of majority will be paid to the parent(s) or legal guardian on his/her behalf.

8 Authorization and Signature

This Section must be ***signed and dated*** in ink by the plan member

Reset Form

Print Form

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that I may be required to provide proof of evidence of this information. I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions, if applicable. I authorize my Employer, the Policyholder, the Plan Administrator and the Insurance Company (ies) or their re-insurers, or their respective agents to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any under this plan.
In the case of death, I expressly authorize my Employer, the Policyholder, the Plan Administrator, the Beneficiary, heir or liquidator of my estate to provide the Life Insurance Company, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.
This consent is valid for the purpose of this contract, or any modification, extension or reinstatement thereof.
A photocopy of this consent is valid as the original if it is used for information-sharing purposes.

Plan member signature

Date signed (mm/dd/yyyy)

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