

Employee Benefits Change Form

EMPLOYER: _____ LOCATION: _____

EMPLOYEE NAME: _____ PIN: _____

Addition/Deletion of Dependent(s) - Extended Health/Dental Coverage Changes

Type of Change: Addition Termination (please complete Waiver section below)

Changes to: Extended Health Care Dental Care Both Benefits

If adding a spouse, please indicate date of marriage or co-habitation: _____

If spouse and/or dependent was previously covered under a different plan, please provide:

Name of previous carrier: _____

Extended Health Care Policy No.: _____ Dental Care Policy No.: _____

Cancellation Date of previous coverage: _____

Dependent Information: (If a dependent child is an Over-Age Student, please complete an Over-Age Dependent Form available from your Plan Administrator. If a dependent child is disabled, please see your Plan Administrator for additional information requirements.)

| LIST OF DEPENDENTS | | | GENDER (Male/Female) | DATE OF BIRTH MM/DD/YYYY | RELATIONSHIP TO EMPLOYEE | MSP PERSONAL HEALTH NO. | FULL-TIME STUDENT (Yes/No) | DISABLED (Yes/No) | SMOKER (Yes/No) | EFFECTIVE DATE OF COVERAGE MM/DD/YYYY |
|--------------------|------------|---------|-------------------------|-----------------------------|-----------------------------|-------------------------------|----------------------------------|----------------------|--------------------|--|
| LAST NAME | FIRST NAME | INITIAL | | | | | | | | |
| 01 | | | | | SPOUSE | | -- | -- | | |
| 02 | | | | | | | | | -- | |
| 03 | | | | | | | | | -- | |
| 04 | | | | | | | | | -- | |
| 05 | | | | | | | | | -- | |
| 06 | | | | | | | | | -- | |

PLEASE INDICATE YOUR DESIRED COVERAGE LEVEL: All future changes should be reported to your Plan Administrator.

Extended Health Care (EHC) = _____ (S/C/F/0) Dental Care = _____ (S/C/F/0)

S=Self Only **C**=Self & One Dependent **F**=Self & Two or more Dependents **0**=No coverage for myself or my Dependents -- Please complete Waiver section.

CO-ORDINATION OF BENEFITS – Are you covered under another Benefits Plan?

Extended Health _____ (Yes/No) Coverage Level _____ (S/C/F) Dental _____ (Yes/No) Coverage Level _____ (S/C/F)

WAIVER OF EXTENDED HEALTH AND/OR DENTAL COVERAGE - I understand the plan of Group Insurance offered to me. However, if permitted by the provisions of the plan, I decline to participate in the following:

EXTENDED HEALTH For: myself and/or my Dependents **DENTAL CARE** For: myself and/or my Dependents

REASON FOR REFUSAL: Comparable coverage is provided for me and/or my dependents under the following benefits plan:

Name of Insurer/Employer: _____ Group No. _____

I recognize that if my alternate coverage terminates, I must apply for coverage under my employer's Group Plan within **31 days** of the termination date. Should I fail to do so, I may be required to submit, at my own expense, satisfactory evidence of insurability for myself and my dependents, or I may be required to pay premiums retroactive to the date of eligibility or benefits may be restricted or denied.

EMPLOYEE'S SIGNATURE **DATE**

EMPLOYER USE ONLY

| DATE CHANGE REQUESTED (MM/DD/YY) | TYPE OF CHANGE | ANNUAL EARNINGS | # OF HOURS/ F.T.E. | EFFECTIVE DATE OF COVERAGE/CHANGE (MM/DD/YYYY) | CLASS | COST CODE | EHC | DEN | MSP |
|----------------------------------|----------------|-----------------|--------------------|--|-------|-----------|-----|-----|-----|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

BA = Add Employee T = Terminate Employee D = Dependent Status/Change B = Change of Beneficiary V = Voluntary Benefit Change C = Change of Class S = Change of Salary

FIRST NAME: _____ LAST NAME: _____

FIRST NAME: _____

LAST NAME: _____



CHANGE OF BENEFICIARY - Group Life and Basic Accidental Death Benefits

Please contact your Plan Administrator to change your Optional/Voluntary benefits beneficiary designation.

I hereby appoint the beneficiaries listed below to receive the Group Plan Insurance benefits which are payable in the event of my death. I reserve the right, without the consent of the beneficiaries, to further change the beneficiary subject to any statutory restrictions. I also hereby revoke any previously designated beneficiaries, subject to any statutory restrictions. If no designated beneficiary survives me, settlement will be made to my Estate. I understand that if I appoint a minor (under the age of 19) as my beneficiary, I must complete the declaration above appointing a Trustee.

| Full Name of Beneficiary(ies) <small>First Name Last Name</small> | Date of Birth <small>(MM/DD/YYYY)</small> | Relationship | % Share |
|---|--|--------------|---------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

| Contingent Beneficiary(ies) <small>First Name Last Name</small> | Date of Birth <small>(MM/DD/YYYY)</small> | Relationship | % Share |
|---|--|--------------|---------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

EMPLOYEE'S SIGNATURE **X** DATE: **X**

For Quebec Residents Only: In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If beneficiary is shown as irrevocable, his/her consent is required to change it.

Quebec Residents Only: If the spouse is designated as beneficiary, this designation is:

Revocable Irrevocable

DECLARATION APPOINTING TRUSTEE (Complete if Beneficiary is under the age of majority)

I do hereby appoint _____ as Trustee to receive any amount due to any Beneficiary(ies) under 19 years of age and declare the receipt of such Trustee shall be a good discharge to The Group Insurer(s) for the amount so paid.

Address of Trustee: _____ Phone: () _____
Area Code

And I do hereby authorize such Trustee, at his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such beneficiary(ies).

EMPLOYEE'S SIGNATURE **X** DATE: **X**

CHANGE OF NAME OF INSURED

I hereby request my name be changed

FROM: _____
Last Name First Name

TO: _____
Last Name First Name

EMPLOYEE'S SIGNATURE **X** DATE: **X**

CHANGE OF ADDRESS

This is to notify that my home address has changed effective _____

My new address is:

Apt. No. Street Address City Province Postal Code

EMPLOYEE'S SIGNATURE **X** DATE: **X**

Additional Comments:

