GROUP INSURANCE PLAN
EMPLOYEE CHANGE REQUEST

Company Name:	**Firm #:**	**Policy #:**
Employee Name:	**Certificate #:**	

☐ **Terminate Employee's Coverage** **Last Day of Work (D/M/Y):**

☐ **Reinstate Employee's Coverage** **Date of Return to Work (D/M/Y) :**

☐ **New Marital Status** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

☐ **Common Law (Please provide the date you began living together)**

Date of Change (D/M/Y):

☐ **Dependent Child(ren)** **Date of Birth (D/M/Y):** **Date of Birth (D/M/Y):**

Date of Change (D/M/Y): **Date of Change (D/M/Y):**

☐ **Name Change** **Previous Name:** **New Name:**

Date of Change (D/M/Y):

☐ **Salary Change** **New Annual Earnings:** **Date of Change (D/M/Y):**

☐ **Class Change** **Previous Class:** **New Class:**

Date of Change (D/M/Y):

☐ **New Beneficiary:**

I hereby name the following revocable beneficiary (Irrevocable in the province of Quebec) or any Life and/or Accidental Death and Dismemberment Insurance benefits payable as a result of my participation in this plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid.

Please Note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check here: ☐ Revocable

I hereby make the beneficiary designated below. I may elect to change this beneficiary designation at any time.

Beneficiary's Full Name:	**Relationship to You:**
Trustee's Name (if applicable):	**Relationship to Minor Beneficiary:**

Please sign here:

____________________ ____________________

Employee's Signature Date of Change (D/M/Y)

IRREVOCABLE BENEFICIARY CONSENT

I understand that I have been named as an irrevocable beneficiary under the group policy referenced above. I hereby consent to the (policyholder/plan member) changing the beneficiary from myself to another person as determined by the (policyholder/plan member).

Irrevocable Beneficiary's Full Name:

Irrevocable Beneficiary's Signature	Date of Change (D/M/Y)

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Employer Sign Here:

Employer's Signature	Date (D/M/Y)

Coverage changes are subject to the terms of the group insurance plan and any applicable legislation. Return the completed form to you Employer who will send it to the Plan Administrator.