

EMPLOYEE CHANGE REQUEST

For office use only

Effective Date	Certificate #
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To be Completed by the Employer (Please print clearly in INK)

Firm/Company Name		Firm/Division #	
Employee Name		Certificate #	
<input type="checkbox"/> Occupation Change	New Occupation		Effective Date (YYYY/MM/DD)
<input type="checkbox"/> Salary Change	Regular Earnings \$	Frequency	<input type="checkbox"/> Annually <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Hourly
			If hourly, # hours/week
<input type="checkbox"/> Transfer Division/Class	Old Division/Class	New Division/Class	Effective Date (YYYY/MM/DD)
<input type="checkbox"/> Terminate Employee's Coverage	<input type="checkbox"/> Employee Left Employment <input type="checkbox"/> Other Reason (please specify)		
Last Day of Work (YYYY/MM/DD)			
<input type="checkbox"/> Reinstate Employee's Coverage	Date of Return to Work (YYYY/MM/DD)		
Employer's Signature		Date	

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To be Completed by the Employee (Please print clearly in INK)

Check the changes you are making and provide ALL the information requested for EACH section you check.

<input type="checkbox"/> Address Change	New Address	
	Province of Employment (if different)	
<input type="checkbox"/> Employee Name Change	From	Date of Change (YYYY/MM/DD)
	To	
	Reason for Change	
<input type="checkbox"/> New Marital Status <i>(If checked, please see Dependent Status and New Beneficiary below)</i>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Date (YYYY/MM/DD)
	<input type="checkbox"/> Common Law (Please provide date you began living together)	
<input type="checkbox"/> Add Benefits	<input type="checkbox"/> Health <input type="checkbox"/> Dental <i>(Complete Dependent Status if requesting family coverage)</i> Previously covered under another plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, up to (YYYY/MM/DD)	
<input type="checkbox"/> Cancel Duplicate Coverage <input type="checkbox"/> Change Duplicate Coverage	<input type="checkbox"/> Health <input type="checkbox"/> Dental Other Insurer's Name	
	Date your coverage began in the above plan (YYYY/MM/DD)	
	What group benefit coverage does your spouse have through his/her employer? Healthcare <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None Dental <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None	
<input type="checkbox"/> Dependent Status	<input type="checkbox"/> Change from family to single coverage	Date of Change (YYYY/MM/DD)
	Reason	
	<input type="checkbox"/> Change from single to family coverage	Date of Change (YYYY/MM/DD)
	Reason	

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List all your dependents affected by the change, including your spouse: (Please print clearly in INK)

	Date of Change (YYYY/MM/DD)	First and Last Name	Relationship*	Birthdate (YYYY/MM/DD)	Gender
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete					
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete					
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete					

Coverage under your Provincial Health plan is necessary in order for you and your dependents to be eligible for Extended Health coverage.

*If a dependent is disabled, please complete the *Request for Over Age Disabled Dependent Coverage* form. If a dependent is an over age dependent, please complete the *Request for Over Age Dependent Coverage* form. Please see your Plan Administrator for details.

Beneficiary Designation – Please print clearly in INK (crossed out or revised information must be initialed by the employee)

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.

Last Name	First Name	Middle Initial	% of Benefit	Relationship to Employee

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Divided: As per percentages above (must total 100%) In equal shares to survivor(s)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here: **Revocable**, I may change this designation at any time

Trustee/Administrator Designation

If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Full Name	Relationship to Employee
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If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.

For Quebec Only: Where this appointment is governed by Quebec law, "trustee" shall be read as "administrator", and all terms interpreted accordingly. The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

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Employee Signature (Please sign and date here)

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

I authorize Maximum Benefit to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.maximumbenefit.ca or from the administrator of my benefit program.

A photocopy or electronic version of this **Declaration and Authorization** is as valid as the original.

A photocopy or electronic version of this form is **not valid** for recording beneficiary designations.

Signature of Employee _____ Date _____