



Quebec and Atlantic Provinces
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario and Western Provinces
522 University Avenue
Toronto, Ontario M5G 1Y7

Group
INSURANCE

CHANGE OF RECORD

Please print in ink and sign.

Effective date of change: Y M D

BASIC INFORMATION

Policyholder's name (Employer/organization) _____ Group policy no. _____
Division no. _____ Class no. _____ Location _____ Certificate no. _____
Member's name (Please record you old name, if name change is being requested) _____

CHANGE OF NAME OR ADDRESS

Last name _____ First name _____
Reason: Correction Marriage/ Civil Union - Date Y M D Divorced / separated - Date Y M D
Address _____ Postal code _____
No. Street City Province

CHANGE OF STATUS (Please specify the details in the dependents section.)

I wish to change my status to: Individual Family Other _____
Reason:
 Marriage / Civil Union - Date Y M D Divorced / Separated - Date Y M D
 Common-law - Date cohabitation began: Y M D Other _____ - Date Y M D
 Coverage under spouse's plan terminated - Termination date Y M D

Dependents:

	Last name	First name	Sex	Date of birth		
<input type="checkbox"/> Add spouse			<input type="checkbox"/> M	Y M D		
<input type="checkbox"/> Delete spouse			<input type="checkbox"/> F			
<input type="checkbox"/> Add child			<input type="checkbox"/> M		Full-time student	Handicapped
<input type="checkbox"/> Delete child			<input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add child			<input type="checkbox"/> M		Full-time student	Handicapped
<input type="checkbox"/> Delete child			<input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your spouse is insured for Health and Dental Benefits, please complete section entitled "COORDINATION AND WAIVING OF BENEFITS".
If you should wish to apply for Optional Life Insurance on your spouse (if available), please complete the section entitled "CHANGE IN OPTIONAL BENEFITS".

OVERAGE DEPENDENTS STATEMENT

Last name _____ First name _____ Sex M F Date of birth Y M D
If a full time student, name of educational Institute attending _____
Period: From: Y M D to Y M D
If handicapped, nature of handicap _____ Date handicap commenced Y M D
Last name _____ First name _____ Sex M F Date of birth Y M D
If a full time student, name of educational institute attending _____
Period: From: Y M D to Y M D
If handicapped, nature of handicap _____ Date handicap commenced Y M D

COORDINATION AND WAIVING OF BENEFITS (To complete only if you and/or your dependents are covered for similar benefits under another plan.)

Check the appropriate boxes:
Coverage of the spouse's plan
Health: Individual Family Waived
Dental: Individual Family Waived
Spouse's name _____ Spouse's group policy no. _____
Spouse's certificate no. _____ Spouse's certificate no. _____
Spouse's insurance company _____
Waiving the member's coverage
 Health Insurance
 Dental Care Insurance
Waiving the dependent's coverage
 Health Insurance
 Dental Care Insurance

If you waive the coverage and you wish to request it at a later date, certain conditions may apply. Please contact your plan administrator for further details.
YOU MUST COMPLETE THE MEMBER'S CONFIRMATION AND AUTHORIZATION ON THE REVERSE SIDE.
FAILURE TO DO SO WILL RESULT IN YOUR CHANGE NOT BEING PROCESSED.

