GROUP BENEFITS
HEALTH & DENTAL CHANGE FORM

INSTRUCTIONS

Use this form to report changes in an employee's marital status, name, dependent life insurance, health and/or dental coverage information including dependent information or coordination of benefits information. **Only complete the information that is changing and include the effective date.**
A separate change form is to be used for reporting changes affecting Life Insurance coverage.

Please submit the physically signed copy to:

- **Email:** benefits@mearie.ca
- **Fax: 905-265-5302**
- **Mail: The MEARIE Group – 3700 Steeles Avenue West, Suite 1100, Vaughan, Ontario, L4L 8K8**

SECTION #1: PLAN MEMBER INFORMATION

EMPLOYER NAME		DIVISION NUMBER	
EMPLOYEE NAME First Name Middle Name Last Name		CLASS	ID NUMBER

EFFECTIVE DATE OF CHANGE	MONTH	DATE	YEAR

SECTION #2: CHANGE TO MEMBER DATA

☐ **New Name:**

First Name Last Name

☐ **New Mailing Address:**

Street City Province Postal Code

☐ **Change in Marital Status:**

- ☐ Single
- ☐ Common-law*

*Please confirm the first date you resided together (MM/DD/YY) _____

- ☐ Marriage
- ☐ Divorce / Legal Separation
- ☐ Widowed

☐ **Dependent Life Change:**

- ☐ Add Coverage
- ☐ Update Existing Dependent Coverage
- ☐ Terminate Coverage

SECTION #3: BENEFICIARY DESIGNATION

Please PRINT your beneficiary's name in FULL. If more than one beneficiary is named, indicate the percentage for each beneficiary (if no percentage is indicated for multiple beneficiaries we will assume equal shares for each). If your beneficiary is under the age of majority, a trustee must be appointed.

PRIMARY BENEFICIARY:

First Name	Middle Name	Last Name	Under Age 18	Relationship	% Share
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable. The designation above will supersede any prior beneficiary designation. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ REVOCABLE

CONTINGENT BENEFICIARY:

In the event that there are no surviving Primary Beneficiary at the time of my death, the Contingent Beneficiary(ies) listed below will be entitled to receive the proceeds of all life insurance policies insured.

First Name	Middle Name	Last Name	Under Age 18	Relationship	% Share
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable. The designation above will supersede any prior beneficiary designation. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ REVOCABLE

TRUSTEE NOMINATION:

Identify a trustee when appointing a minor as a beneficiary for your life insurance coverage under The MEARIE Group program. You can name an individual (an "administrator" or "trustee") other than the child's parents, or other legal guardian when applicable, to manage the proceeds on their behalf until the child reaches the age of majority (age 18 in Ontario). Before designating a trustee, we recommend you consult with a legal advisor and with the proposed trustee.

If you are separated or divorced you can name someone other than the child's other parent as the administrator/trustee which is allowable unless the minor beneficiary resides in Quebec. Quebec courts have ruled that when a death benefit under a life insurance policy is payable to a minor beneficiary, it must be paid to the child's parent(s) (or other legal guardian when applicable) and not to any other administrator/trustee named under the life insurance policy.

Full Name: _____ **Relationship to Plan Member:** _____

Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable. The designation above will supersede any prior beneficiary designation. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ REVOCABLE

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SECTION #4: CHANGES TO HEALTH AND DENTAL BENEFITS

I wish to participate in: **Health:** ☐ **Single Coverage** ☐ **Family Coverage** ☐ **Waiving Coverage ***
Dental: ☐ **Single Coverage** ☐ **Family Coverage** ☐ **Waiving Coverage ***

DECLARATION OF WAIVING COVERAGE:

☐ I am waiving coverage for **myself, my spouse and my dependent children.** We have similar coverage under my spouse`s group insurance plan.
We request **NOT** to be covered for: ☐ **Health Care** ☐ **Dental Care**

☐ I am waiving coverage for my **spouse and dependent children only.** We have similar coverage under my spouse`s group insurance plan.
My **spouse and dependent children** are **NOT** to be covered for: ☐ **Health Care** ☐ **Dental Care**

CO-ORDINATION OF BENEFITS:

If your spouse is covered for health and/or dental under their employer's plan and you wish to waive coverage **OR** coordinate benefit coverage under his/her plan, provide details below.

BENEFIT	COVERAGE		NAME OF SPOUSE'S EMPLOYER	NAME OF SPOUSE'S INSURANCE COMPANY	POLICY NUMBER
	Single	Family			
Health	☐	☐			
Dental	☐	☐			

If you lose coverage under your spouse's plan, you must apply for coverage under this program within 31 days of the loss of coverage. If you do not apply within 31 days you and your dependents may be required to provide proof of good health acceptable to the insurance company. If approved, coverage will commence on the date the insurer approves coverage.

SECTION #5: CHANGES TO DEPENDENT INFORMATION

Dependent Relationship	First Name | Middle Name | Last Name	Gender	Date of Birth MM	DD	YY	Dependent Student*	Handicapped Child
SPOUSE		☐ MALE | ☐ FEMALE | ☐ OTHER				☐ YES | ☐ NO	☐ YES | ☐ NO
CHILD		☐ MALE | ☐ FEMALE | ☐ OTHER				☐ YES | ☐ NO	☐ YES | ☐ NO
CHILD		☐ MALE | ☐ FEMALE | ☐ OTHER				☐ YES | ☐ NO	☐ YES | ☐ NO
CHILD		☐ MALE | ☐ FEMALE | ☐ OTHER				☐ YES | ☐ NO	☐ YES | ☐ NO

***NOTE: If dependent child is a full-time student, under age 25, indicate the name of university/college being attended including dates of attendance.**

Name of University/College: _____ **Date Attending FROM:** _____ **TO:** _____

SECTION #6: AUTHORIZATION

EMPLOYEE: I hereby apply for the Group Insurance Benefit(s) for which I am, or may later become eligible for and authorize the necessary deductions, if any, to be made by my employer from my earnings. I am authorized to disclose information about my spouse and dependents in order to enroll them under the plan. If the Member Identification Number is my Social Insurance Number, I authorize The MEARIE Group, its representatives and any service providers working with The MEARIE Group to use or exchange information collected in this form to underwrite, administer and adjudicate claims. Furthermore, I also authorize the use of such number for tax reporting identification and the administration of my benefits. I certify that the information given is true, correct and complete to the best of my knowledge.

Signature:_____ **Date:**_____

EMPLOYER: The undersigned, on behalf of the employer, hereby certifies that to the extent that available records and information permit, the statements on this form are true and complete and no material information has been omitted or withheld.

Signature:_____ **Date:**_____

At The MEARIE Group, we recognize and respect every individual's right to privacy. We use the personal information provided to determine your eligibility for coverage and administer the group benefit plan.

TMG Revised: Aug 1, 2023