GROUP BENEFITS
LIFE CHANGE FORM

INSTRUCTIONS

Use this form to report employee retirements, changes in earnings, classification, Life Insurance coverage elections & smoking declarations (employee/spouse), beneficiary designations, or terminations. **Only complete the information that is changing and include the effective date.**
A separate change form is to be used for reporting changes affecting health and/or dental coverage and dependent information.

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 Division:** ☐ **New Class:** ☐ **New ID Number:**

☐ **New Earnings:** $ ____________________ per annum

☐ **New Working Hours:** ____________________ per week

☐ **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**

☐ **Change in Work Status:**

☐ **Maternity / Parental Leave**

Start Date: *(MM/DD/YY)*
____

End Date: *(MM/DD/YY)*
____

Benefits Continued? ☐ YES | ☐ NO

☐ **Retirement**

**Is the employee eligible for Retirement Life Insurance?*

Retiree Class* #_________________

Final Earnings: $___________________

SECTION #3: CHANGE TO EMPLOYEE SMOKING HABITS

☐ **Non-Smoker:** I certify as a true fact that I have **NOT** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below.

☐ **Smoker:** I certify as a true fact that **I have** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below.

I understand and agree that the premiums charged for my insurance coverage are based in part on the statements given by me on this form. I certify that the statements are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that all Optional and Supplementary Life insurance coverage is voidable by the insurer. I further agree that in such event the insurer's liability is limited to paying to the designated beneficiary/beneficiaries the amount of any premium I paid for insurance.

EMPLOYEE SIGNATURE: ____ **DATE:** ______________________________

SECTION #4: CHANGE IN LIFE INSURANCE BENEFITS SELECTION

EMPLOYEE BASIC TERM LIFE and OPTIONAL LIFE INSURANCE

Indicate the Plan Option selection by placing a ✓ in the appropriate box

THE FOLLOWING STATEMENTS APPLY TO PLAN OPTIONS 1, 2, 3 AND 4.

I understand that my application to enroll in a Plan Option which increases my current amount of insurance is subject to the insurer's approval of satisfactory evidence of insurability. ***(NOTE: To apply for increased insurance a health questionnaire must be completed and attached to this form.)***
I further understand that if I reduce my amount of insurance at this time, evidence of insurability satisfactory to the insurer, will be required should I later wish to increase my coverage.
I am also aware of the Retirement Insurance Coverage applicable to me.

PLAN OPTION:	#1 ☐	#2 ☐	#3 ☐	#4 ☐
Basic Term Insurance	150%	175%	175%	175%
Additional (Optional) Term Insurance	Nil	25%	75%	125%
TOTAL INSURANCE	**150%**	**200%**	**250%**	**300%**

Note: All amounts of insurance are rounded upward to the nearest $1,000

EMPLOYEE SUPPLEMENTARY LIFE INSURANCE

☐ New Application Amount Applied for:
$_______________________________

☐ Application to Increase Amount to:
$_______________________________

**Coverage is available in units of $10,000 to a maximum of $250,000*

****NOTE: Any application to add or increase coverage is subject to satisfactory evidence of insurability.***
You must complete a health questionnaire and attach the original to this form.

☐ Please **CANCEL** my Supplementary Life Insurance

☐ Please **REDUCE** my Supplementary Life Insurance to:
$_______________________________

I understand that if I cancel or reduce my spouse optional life insurance at this time evidence of insurability, satisfactory to the insurer, will be required if I wish to re-apply for the coverage that has been cancelled or reduced.

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SPOUSE OPTIONAL LIFE INSURANCE

☐ New Application Amount Applied for:

$_________________________________

☐ Application to Increase Amount to:

$_________________________________

Coverage is available in units of $10,000 to a maximum of $250,000

NOTE: Any application to add or increase coverage is subject to satisfactory evidence of insurability.
You must complete a health questionnaire and attach the original to this form.

☐ Please **CANCEL** my Spouse Optional Life Insurance

☐ Please **REDUCE** my Spouse Optional Life Insurance to:
$_________________________________

I understand that if I cancel or reduce my insurance at this time, evidence of insurability satisfactory to the insurer will be required if I wish to re-apply for the coverage that has been cancelled or reduced.

SPOUSE NAME: **First Name** ______________________ **Middle Name** ______________________ **Last Name** ______________________	**GENDER:** ☐ MALE ☐ FEMALE ☐ OTHER	**DATE OF BIRTH** *(MM/YY/DD)*

SPOUSE DECLARATION OF SMOKING HABITS: *Please check off the appropriate box below:*

☐ **Non-Smoker:** I certify as a true fact that I have **NOT** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below

☐ **Smoker:** I certify as a true fact that **I have** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below.

I understand and agree that the premiums charged for my insurance coverage are based in part on the statements given by me on this form. I certify that the statements are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that the Spousal Optional Life insurance coverage is voidable by the insurer. I further agree that in such event the insurer's liability is limited to refunding the amount of any premium paid for insurance on my behalf.

SPOUSE SIGNATURE: ______________________________________ **DATE:** ______________________________

SECTION #5: 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

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.