EMPLOYEE BENEFIT PROGRAM

HEALTH & DENTAL - GENERAL CHANGE FORM

PROCESSING 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 send the **original** signed form to **The MEARIE Group – 3700 Steeles Avenue West, Suite 1100, Vaughan, Ontario L4L 8K8**

GENERAL INFORMATION (Part A)

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

EFFECTIVE DATE OF CHANGE	Year	Month	Day

PLEASE IDENTIFY THE TYPE OF CHANGE REQUESTED (Part B) – ***check off the appropriate box***

☐ **Change in Marital Status to:**

☐ **Single** ☐ **Common-Law*** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

***If you are reporting a common-law cohabitation relationship, please confirm the first date you resided together**____
(Year/Month/Day)

When reporting a change in your marital status, please update your beneficiary designation if necessary in Part C of this form. If you need to update your Life Insurance coverage for your lifestyle change, please complete a separate LIFE General Change Form

☐ **Change in Employee's Name to: Last Name:**_____________________________________ **First Name:** _______________________________

☐ **Dependent Life Change:** ☐ **Add Coverage** ☐ **Update Existing Dependent Record** ☐ **Terminate Coverage**

☐ **New Mailing Address**

Street City Province Postal Code

☐ **BENEFICIARY INFORMATION (Part C)**

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.

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

☐ **CHANGE IN HEALTH AND/OR DENTAL COVERAGE ELECTIONS - ENROLLMENT INFORMATION (Part D)**

☐ **Health Coverage:** ☐ **Single** ☐ **Family** ☐ **Waiving Coverage***

☐ **Dental Coverage:** ☐ **Single** ☐ **Family** ☐ **Waiving Coverage***

*** If waiving coverage, please complete declaration Waiving Coverage in Part D on the reverse side of this form.**

Effective Date of Change: (YY/MM/DD)

If you are applying for coverage that was previously waived, or changing your coverage status, please indicate the reason for this change request below:

☐ Change in marital status ☐ Spouse gained/lost coverage under his/her employer's plan ☐ Other (specify)______________________________________

Effective date of change in coverage noted above : Year _______________ Month _______________ Day_______________

Please See Reverse

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☐ **WAIVE COVERAGE AND/OR COORDINATE COVERAGE (Part E)**

Please check off the appropriate box below:

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

OR

☐ I am waiving coverage for my **spouse and dependent children only.** We now 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**

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

COORDINATION OF COVERAGE AND/OR WAIVER OF COVERAGE DETAILS

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.

☐ **CHANGE IN DEPENDENT INFORMATION (Part F)**

Dependent Relationship	First Name	Middle Name	Last Name	Gender	Date of Birth			Dependent Student*	Handicapped Child
					Year	Month	Day		
SPOUSE				☐ Male ☐ Female					
Child				☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
Child				☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
Child				☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
Child				☐ Male ☐ Female				☐ 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**

☐ **AUTHORIZATION (Part G)**

EMPLOYEE

I hereby apply for, or wish to change 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.