EMPLOYEE BENEFIT PROGRAM

LIFE - GENERAL CHANGE FORM

PROCESSING 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 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***

☐ **New Earnings : $ ________________________________**
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual

No. Hours Per Week

☐ **New Class**

☐ **New Division**

☐ **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)**

☐ **Change in Employee's Name to: Last Name:**__________________________________ **First Name:** ______________________________

☐ **New Mailing Address**

Street City Province Postal Code

☐ **Retirement** – Is this employee eligible for Retirement Life Insurance? ☐ **Yes** ☐ **No** ***If yes, please confirm final annual earnings: $***

☐ **Termination** (YY/MM/DD)

☐ **Change Member I.D. # to:**

☐ **CHANGE IN EMPLOYEE LIFE INSURANCE COVERAGE ELECTIONS (Part C)**

BASIC TERM LIFE AND EMPLOYEE OPTIONAL TERM LIFE

Indicate the new 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

☐ **CHANGE IN EMPLOYEE SMOKING STATUS (Part D)**

DECLARATION OF SMOKING HABITS: *Please check off the appropriate box below if you are **declaring a change** at this time:*

☐ **Non Smoker:** I certify as a true fact that I have **NOT** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or used marijuana 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 used marijuana 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:**

Please See Reverse

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☐ **CHANGE IN EMPLOYEE SUPPLEMENTARY LIFE INSURANCE (Part E)**

☐ **New Application Amount Applied for**: **OR** ☐ **Application to Increase Amount to**: $____________________________ $______________________________ Coverage is available in units of $10,000 to a maximum benefit 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 Coverage **OR** ☐ Please **REDUCE** my Supplementary Life Insurance Coverage 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.

IMPORTANT NOTE: If you are applying to ***add, increase or reduce*** your amount of Employee Supplementary Life Insurance coverage you must complete the **Declaration of Smoking Habits** on Part D of this form.

☐ **CHANGE IN SPOUSE OPTIONAL LIFE INSURANCE (Part F)**

☐ **New Application Amount Applied For:** **OR** ☐ **Application to Increase Amount to:** $____________________________ $______________________________ Coverage is available in units of $10,000 to a maximum benefit of $250,000 **NOTE: Any application to add or increase coverage is subject to satisfactory evidence of insurability. Your spouse must complete a health questionnaire and attach same to this form.**	☐ Please **CANCEL** my Spouse Optional Life Insurance Coverage **OR** ☐ Please **REDUCE** my Spouse Optional Life Insurance Coverage 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's First Name Last Name	Gender ☐ Male ☐ Female	Date Of Birth (YY/MM/DD)

DECLARATION OF SMOKING HABITS: *Please check off the appropriate box below if you are **declaring a change** at this time:*

☐ **Non Smoker:** I certify as a true fact that I have **NOT** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or used marijuana 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 used marijuana 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'S SIGNATURE: **DATE:**

☐ **CHANGE IN BENEFICIARY INFORMATION (Part G)**

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		

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

AUTHORIZATION (Part H)

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.