



Firm # _____	Certificate # _____
Effective Date _____	

**E M P L O Y E E C H A N G E R E Q U E S T**



**TO BE COMPLETED BY THE EMPLOYER**

Company Name \_\_\_\_\_ Firm # \_\_\_\_\_

Employee Name \_\_\_\_\_ Certificate # \_\_\_\_\_

**Terminate Employee's Coverage**     Employee Left Employment    Last Day of Work (DD/MM/YY) \_\_\_\_\_

Other Reason (please specify) \_\_\_\_\_

**Reinstate Employee's Coverage**    Date of Return to Work (DD/MM/YY) \_\_\_\_\_

Employer's Signature \_\_\_\_\_ Date \_\_\_\_\_



**TO BE COMPLETED BY THE EMPLOYEE**

**Check the changes you are making and provide ALL the information requested for EACH section you check.**

**Add Benefits**     Health     Dental (Complete *Dependent Status* if requesting family coverage)  
Previously covered under another plan?     No     Yes, up to (DD/MM/YY) \_\_\_\_\_

**Cancel Duplicate Coverage**     Health     Dental    Other Insurer's Name \_\_\_\_\_  
Date your coverage began in the above plan (DD/MM/YY) \_\_\_\_\_

**New Marital Status**     Single     Married     Widowed     Separated     Divorced    Date (DD/MM/YY) \_\_\_\_\_  
 Common Law (Please provide date you began living together) \_\_\_\_\_

**Employee Name Change**    Previous Name \_\_\_\_\_    Date of Change (DD/MM/YY) \_\_\_\_\_  
Reason for Change \_\_\_\_\_

**Dependent Status**

<input type="checkbox"/> Add new dependent(s) listed below	_____	Reason _____	Date of Change (DD/MM/YY) _____
<input type="checkbox"/> Delete dependent(s) listed below	_____	Reason _____	Date of Change (DD/MM/YY) _____
<input type="checkbox"/> Change from family to single coverage	_____	Reason _____	Date of Change (DD/MM/YY) _____
<input type="checkbox"/> Change from single to family coverage	_____	Reason _____	Date of Change (DD/MM/YY) _____

**List all your dependents affected by the change, including your spouse:**

Relation	First Name	Last Name (if different)	Birthdate (DD/MM/YY)	Sex (M/F)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 or over)
Spouse	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

**New Beneficiary:** I hereby name the following revocable beneficiary of any Life Insurance benefits payable as a result of my participation in this Plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Beneficiary's Full Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

Trustee's Name (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE SIGN HERE** ▶ Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_