MAXIMUM Benefit®

JG11

# EMPLOYEE CHANGE REQUEST

**For ofiice use only**

| Effective Date | Certificate # |
|---|---|
| | |

## To be Completed by the Employer (Please print clearly in INK)

1

| | | | | | | |
|---|---|---|---|---|---|---|
| Firm/Company Name | | | | | | Firm/Division # |
| Employee Name | | | | | | Certificate # |
| ❑ **Occupation Change** | | New Occupation | | | | Effective Date (YYYY/MM/DD) |
| ❑ **Salary Change** | Regular Earnings $ | Frequency | ☐ Annually ☐ Bi-Weekly | ☐ Weekly ☐ Semi-Monthly | ☐ Monthly ☐ Hourly | If hourly, # hours/week |
| ❑ **Transfer Division/Class** | | Old Division/Class | | New Divison/Class | | Effective Date (YYYY/MM/DD) |
| ❑ **Terminate Employee's Coverage** Last Day of Work (YYYY/MM/DD) | | ❑ Employee Left Employment ❑ Other Reason (please specify) | | | | |
| ❑ **Reinstate Employee's Coverage** | | | | | | Date of Return to Work (YYYY/MM/DD) |
| Employer's Signature | | | | | | Date |

## To be Completed by the Employee (Please print clearly in INK)

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

2

| | | | |
|---|---|---|---|
| ❑ **Address Change** | New Address | | |
| | Province of Employment (if different) | | |
| ❑ **Employee Name Change** | From | | Date of Change (YYYY/MM/DD) |
| | To | | |
| | Reason for Change | | |
| ❑ **New Marital Status** (If checked, please see *Dependent Status* and *New Beneficiary* below) | ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced | | Date (YYYY/MM/DD) |
| | ❑ Common Law (Please provide date you began living together) | | |
| ❑ **Add Benefits** | ❑ Health ❑ Dental (Complete *Dependent Status* if requesting family coverage) Previously covered under another plan? ❑ No ❑ Yes, up to (YYYY/MM/DD) | | |
| ❑ **Cancel Duplicate Coverage** ❑ **Change Duplicate Coverage** *Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.* | ❑ Health ❑ Dental Other Insurer's Name | | |
| | What group benefit coverage does your spouse have through his/her employer? Healthcare ❑ Single ❑ Family ❑ Waived ❑ None Dental ❑ Single ❑ Family ❑ Waived ❑ None | | |
| ❑ **Dependent Status** | ❑ Change from family to single coverage Reason | | Date of Change (YYYY/MM/DD) |
| | ❑ Change from single to family coverage Reason | | Date of Change (YYYY/MM/DD) |

**CONTINUED**

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## 3

**List all your dependents affected by the change, including your spouse: (Please print clearly in INK)**

| | Date of Change (YYYY/MM/DD) | First and Last Name | Relationship* | Birthdate (YYYY/MM/DD) | Gender |
|---|---|---|---|---|---|
| ❑ Add ❑ Change ❑ Delete | | | | | |
| ❑ Add ❑ Change ❑ Delete | | | | | |
| ❑ Add ❑ Change ❑ Delete | | | | | |

Coverage under your Provincial Health plan is necessary in order for you and your dependents to be eligible for Extended Health coverage.

***If a dependent is disabled, please complete the *Request for Over Age Disabled Dependent Coverage* form. If a dependent is an over age dependent, please complete the *Request for Over Age Dependent Coverage* form. Please see your Plan Administrator for details.**

## 4

**Beneficiary Designation – Please print clearly in INK (crossed out or revised information must be initialled by the employee)**

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.

| Last Name | First Name and Initial | % of Benefit | Relationship to Employee | Date of Birth (YYYY/MM/DD) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Divided: ❑ As per percentages above (must total 100%) ❑ In equal shares to survivor(s)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here: ❑ **Revocable**, I may change this designation at any time

### Trustee/Administrator Designation

If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

**Full Name** _____ **Relationship to Employee** _____

*If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.*

**For Quebec Only:** The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

## 5

### Employee Signature (Please sign and date here)

**Declaration and Authorization for the Collection and Communication of Personal Information**

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

I authorize Maximum Benefit to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.maximumbenefit.ca or from the administrator of my benefit program.

A photocopy or electronic version of this **Declaration and Authorization** is as valid as the original.

A photocopy or electronic version of this form is **not valid** for recording beneficiary designations.

Signature of Employee _____ Date _____