British Columbia Public School Employers' Association

The appropriate section(s) below should only be completed as changes to the reverse side are required. **Please return this form to your District Benefits Administrator once completed.** The benefits administrator should file this form for future reference.

# Group Insurance Changes

## Part 1: Employee Identification

| Employee's Last Name | First Name | Initial | ID Number | Provincial Health Plan Number (Care Card) |
|---|---|---|---|---|
| | | | | |

## Part 2: Change in Family Status

Change of coverage requested due to the following "event":

❑ Marriage ❑ Cohabitation ❑ Divorce ❑ Separation ❑ Death ❑ Birth

❑ Other (specify):

Date of Event (M/D/Y)

Revised Extended Health Coverage

❑ Single ❑ Couple ❑ Family ❑ Waived (attach Refusal of Coverage form)

Revised Dental Coverage

❑ Single ❑ Couple ❑ Family ❑ Waived (attach Refusal of Coverage form)

| Add | Delete | No. | Dependant's First Name | Initial | Last Name (if different from Employee) | Birthdate (M/D/Y) | Relationship | Gender (M/F) | Provide name of school below if child is over 21 and studying full time. If child is handicapped, state nature of disability and attach full details. |
|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | | | | | | | | |
| ❑ | ❑ | | | | | | | | |
| ❑ | ❑ | | | | | | | | |
| ❑ | ❑ | | | | | | | | |
| ❑ | ❑ | | | | | | | | |

## Part 3: Change to Spousal or Other Coverage

Change of ❑ Dental ❑ Extended Health coverage requested due to:

❑ Spouse's plan terminated – enroll on BCPSEA plan (ensure Group Insurance Application is up to date or note additions on this form)

❑ Transferring to Spouse's plan - terminate from BCPSEA plan by completing Refusal of Coverage Form

Date of Change (M/D/Y)

Revised Extended Health Coverage

❑ Single ❑ Couple ❑ Family ❑ Waived (attach Refusal of Coverage form)

Revised Dental Coverage

❑ Single ❑ Couple ❑ Family ❑ Waived (attach Refusal of Coverage form)

## Part 4: Change of Beneficiary Designation

| New Beneficiary - Last Name | First Name | Initial | Share of Proceeds | Relationship | Name of Trustee for Beneficiaries Under 18 |
|---|---|---|---|---|---|
| | | | % | | |
| | | | % | | |
| | | | % | | |

To which benefit(s) does this change apply? ❑ All applicable benefits, or: ❑ Basic Life ❑ Optional Life ❑ Basic AD&D ❑ Optional AD&D

## Part 5: Change of Name

| Previous Last Name | First Name | Initial | Date of Change (M/D/Y) |
|---|---|---|---|
| New Last Name | First Name | Initial | ❑ Employee<br>❑ Dependant |

## Part 6: Change of Employee's Address

| Apt / Unit Number | Street Address | | | Date of Change (M/D/Y) |
|---|---|---|---|---|
| City | Province | Postal Code | Phone Number ( ) | |

I hereby confirm the above information is complete, true and correct. I understand that if this application is completed more than 31 days after any change in family status, satisfactory evidence of insurability will be required to add dependants to this plan. I reserve the right to change my beneficiary at any time.

Employee Signature ______________________________ Date Signed ( M / D / Y ) ____________________