



The appropriate section(s) below should only be completed as changes to the Benefits Enrolment Form are required. Once completed, the benefits administrator should file this form for future reference.

Benefits Change Form

Part 1: Employee Identification				
Employee's Last Name	First Name	Initial	District #	Provincial Health Plan Number (Care Card)

Part 2: Change in Family Status									
Change of coverage requested due to the following "event":								Date of Event (mm/dd/yyyy)	
<input type="checkbox"/> Marriage <input type="checkbox"/> Cohabitation <input type="checkbox"/> Divorce <input type="checkbox"/> Separation <input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other (specify):									
Revised Extended Health Coverage					Revised Dental Coverage				
<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)					<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)				
Add	Delete	No.	Dependent's First Name	Initial	Last Name (if different from Employee)	Birthdate (mm/dd/yyyy)	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.
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								

Part 3: Change to Spousal or Other Coverage									
Change of <input type="checkbox"/> Dental <input type="checkbox"/> Extended Health coverage requested due to:								Date of Change (mm/dd/yyyy)	
<input type="checkbox"/> Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form) <input type="checkbox"/> Transferring to Spouse's plan - terminate from PEBT plan by completing Waiver of Coverage Form									
Revised Extended Health Coverage					Revised Dental Coverage				
<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)					<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver 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? <input type="radio"/> All applicable benefits, or: <input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D <input type="checkbox"/> Optional Life <input type="checkbox"/> Optional AD&D						

Part 5: Change of Name			
Previous Last Name	First Name	Initial	Date of Change (mm/dd/yyyy)
New Last Name	First Name	Initial	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent

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 dependents to this plan. I reserve the right to change my beneficiary at any time.

Employee Signature _____ Date Signed (mm/dd/yyyy) _____