the co-operators®
A Better Place For You®

GROUP BENEFITS
PLAN MEMBER CHANGE FORM

To avoid delays, please complete the required information by printing clearly in ink.

1. GENERAL INFORMATION

This section is mandatory

Effective Date of Change _____ (MMM/DD/YYYY)

Group _____ Account _____ Certificate _____

Group Name _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

2. PLAN ADMINISTRATOR SECTION Please check off appropriate box(es)

This section to be signed by the Plan Administrator

The Plan Administrator must confirm eligibility prior to completing this section based on the required hours of your benefit plan.

Retain a copy for your records

☐ **SALARY, OCCUPATION, OR RE-INSTATEMENT**

Re-instatement Date _____ (MMM/DD/YYYY) ☐ Full-time ☐ Part-time ☐ Contract

Occupation _____ Class _____

Salary $ _____ Hrs per week _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

☐ **TERMINATION**
I confirm that this employee is no longer eligible for coverage because _____

Signature _____ Date _____ (MMM/DD/YYYY)

Plan Administrator Email _____ Phone Number (_____) _____

3. PLAN MEMBER SECTION Please check off appropriate box(es)

☐ **NAME, ADDRESS, MARITAL STATUS**

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name) _____ (Previous Surname (if applicable))

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Date of Birth _____ (MMM/DD/YYYY)

Marital Status: ☐ Single ☐ *Married/Civil Union ☐ **Common-Law/Partnered

* Date of Marriage _____ (MMM/DD/YYYY)

** I have been living with my common-law/partner since: _____ (MMM/DD/YYYY)

Common-Law Spouse means that I have lived with this person as my spouse or partner for a continuous period of at least 12months, and I have publicly represented this person to be my common-law spouse.

SPOUSE ☐ **ADD** ☐ **REMOVE**

Spouse _____ (First Name) _____ (Initial) _____ (Last Name)

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female

** You are required to complete a Group Health Evidence questionnaire once the disabled dependent reaches the dependent age maximum as listed in the policy.

You must notify Co-operators Life Insurance Company if there are any changes in student status. You must verify your child's student status by submitting confirmation (see page 3) of enrolment by August 15th of each year.

DEPENDENT(S) ☐ **ADD** ☐ **REMOVE**

_____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Full-time student ☐ Disabled Dependent**

_____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Full-time student ☐ Disabled Dependent**

_____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Full-time student ☐ Disabled Dependent**

Percentage allocation will be deemed equal unless indicated otherwise. Percentages must total 100%.

If you do not name a beneficiary, your "estate" will be the beneficiary.

All changes must be initialled by the Plan Member.

If you do not name a trustee, the insurance proceeds will be paid to the minor beneficiary's legal guardian or into court.

A contingent beneficiary is applicable if the primary beneficiary predeceases the Plan Member.

☐ BENEFICIARY CHANGE

Change applies only to checked coverages: ☐ Basic Life/AD&D ☐ Optional Life ☐ Optional AD&D ☐ Paid Up Certificate ☐ All

I, _____ revoke all previous designations for the coverage checked above and declare that all benefits payable under the Policy after my death for the coverage checked, shall be paid to the following:

PRIMARY BENEFICIARY(IES)

% Allocated

First Name	Initial	Last Name	Relationship	% Allocated
				%
				%

CONTINGENT BENEFICIARY

% Allocated

First Name	Initial	Last Name	Relationship	% Allocated
				%

If a designated beneficiary is a minor, please name a Trustee. Insurance proceeds will be paid to the trustee if the beneficiary has not reached the age of majority at the time the insurance proceeds are payable.

Trustee _____ (First Name) _____ (Initial) _____ (Last Name) _____ (Relationship)

In Quebec, the designation of your spouse as a beneficiary is irrevocable unless you declare otherwise. I designate my spouse as revocable beneficiary: ☐ Yes

If Co-ordination of Benefits is terminated or changed, notification is required within 31 days.

☐ CO-ORDINATION OF BENEFITS

Please check if you and your dependent(s) are eligible for the following benefits from another source or company:
☐ Extended Heath Care and Dental Coverage ☐ Extended Health Care Coverage ONLY ☐ Dental Coverage ONLY

Effective Date of Co-ordination of Coverage _____ (MMM/DD/YYYY)

In the event of separation or divorce and the dependent children are eligible for benefits from another source or company, the following information is required:

Dependent _____ (First Name) _____ (Initial) _____ (Last Name)

Dependent _____ (First Name) _____ (Initial) _____ (Last Name)

Parent with custody of child(ren) _____ (First Name) _____ (Initial) _____ (Last Name)

Ex-spouse _____ (First Name) _____ (Initial) _____ (Last Name)

Date of Birth of Ex-spouse _____ (MMM/DD/YYYY)

☐ Co-ordination of Benefits has terminated effective _____ (MMM/DD/YYYY)

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage. After 31 days, proof of insurability may be required and coverage may be restricted or denied.

All changes must be initialled by the Plan Member.

☐ REFUSAL OF BENEFITS

Coverage for Extended Health Care and Dental can be refused if you and/or your dependents have similar coverage through your spouse's employer. I understand the group benefits offered to me, but **I decline** to participate in:

Extended Health Care for: ☐ Myself and my dependents ☐ My dependents only
Dental for: ☐ Myself and my dependents ☐ My dependents only

Spouse's Insurer _____

☐ ADDITION OF BENEFITS

You may add Extended Health Care and/or Dental benefits if your spouse has lost coverage. Effective Date of loss of coverage under your spouse's plan: _____ (MMM/DD/YYYY) . Benefits being added:

Extended Health Care for: ☐ Myself and my dependents ☐ My dependents only
Dental for: ☐ Myself and my dependents ☐ My dependents only

4. PRIVACY AND PLAN MEMBER SIGNATURE

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Co-operators Life Insurance Company will collect, use and disclose personal information about you, your spouse or dependents for the purposes of providing group benefit plan administration, underwriting and claim services. Only authorized personnel have access to your information, and our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. Your personal information may be collected by or transferred to a service provider outside of Canada for processing, storage, analysis or disaster recovery. You can find more details about Co-operators Life Insurance Company's privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact: The Co-operators Privacy Officer: Priory Square, Guelph ON N1H 6P8 Tel: 1-888-887-7773 email: privacy@cooperators.ca (please indicate Co-operators Life Insurance Company in your inquiry)

I have read and understood the section entitled "Privacy" and I consent to the collection, use and disclosure of my personal information for the purposes stated. I hereby apply for group benefits coverage and authorize the deduction from my pay and remittance to Co-operators any contributions required under the group benefits plan. I hereby authorize the employer, group plan administrator, Co-operators or their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange all information necessary for the purposes of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

Plan Member Signature _____ Date _____ (MMM/DD/YYYY)