

# 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 Middle 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 \_\_\_\_\_  Full-time  Part-time  Contract  
MMM/DD/YYYY

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 \_\_\_\_\_  
Plan Administrator 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 Middle 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 \_\_\_\_\_ \*\* Co-habiting since: \_\_\_\_\_  
MMM/DD/YYYY 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 12 months, and I have publicly represented this person to be my common-law spouse.

### **SPOUSE** ADD REMOVE

Spouse \_\_\_\_\_  
First Name Middle Last Name

Date of Birth \_\_\_\_\_  Male  Female  
MMM/DD/YYYY

\*\* You are required to complete a Dependent 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 of enrolment by August 15<sup>th</sup> of each year.

### **DEPENDENT(S)** ADD REMOVE

1. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Middle Last Name MMM/DD/YYYY

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

2. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Middle Last Name MMM/DD/YYYY

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

3. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Middle Last Name MMM/DD/YYYY

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

4. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name Middle Last Name 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.

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

In provinces other than Quebec, if you do not name a trustee, the insurance proceeds will be paid to the minor beneficiary's legal guardian or into court. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf.

**BENEFICIARY CHANGE**

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

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

**PRIMARY BENEFICIARY(IES)**

First Name	Middle	Last Name	Relationship	% Allocated
_____	_____	_____	_____	_____ %
_____	_____	_____	_____	_____ %
_____	_____	_____	_____	_____ %

**CONTINGENT BENEFICIARY**

First Name	Middle	Last Name	Relationship	% Allocated
_____	_____	_____	_____	_____ %

In provinces other than Quebec, if a designated beneficiary is a minor, please name a trustee. Insurance proceed 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 Middle 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 spouse are eligible for the following benefits from another source or company.

Extended Health Care and Dental Coverage  Extended Health Care Coverage ONLY  Dental Coverage ONLY

Co-ordination of Benefits has been added

Co-ordination of Benefits has been terminated

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 spouse/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 spouse/dependents  My spouse/dependents only

Dental for:  Myself and my spouse/dependents  My spouse/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: \_\_\_\_\_. Benefits being added:

MMM/DD/YYYY

Extended Health Care for:  Myself and my spouse/dependents  My spouse/dependents only

Dental for:  Myself and my spouse/dependents  My spouse/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