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# CHANGE FORM

## - DEPENDENT COVERAGE -

## - BENEFICIARY DESIGNATION -

*Please complete the applicable sections and sign and date the reverse side.  
 Return the form for processing.*

**Note:** this form can only be used for changes to your existing records. When enrolling for the first time, please complete an **Application for Group Coverage.**

### PLAN MEMBER'S INFORMATION

Local Union or Employer: \_\_\_\_\_

Name of Plan Member: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City and Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Insurance Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
day / month / year

### CHANGE IN RELATIONSHIP STATUS

Add  Remove

*Date of Marriage or Commencement of Common-Law Relationship*

\_\_\_\_\_ day month year

Date of Separation or Divorce or Co-habitation

Change of Status due to:

\_\_\_\_\_ day month year

- Single       Married       Common-Law       Widowed  
 Separated       Divorced       Cessation of co-habitation

### ADDITION / REMOVAL OF DEPENDENT(S)

I wish to add and/or remove the following dependant(s) from my group benefit plan:

<u>Spouse/Partner's Information</u>	<u>What group benefits coverage does your spouse have through an employer?</u>
last name _____ first name _____ middle initial _____ date of birth (day/month/year) _____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Healthcare</b> → Does this include prescription drug coverage? <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Dentalcare</b> <b>Visioncare</b> <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None

In the case of children of a common-law spouse, I certify that these children reside with me and are dependent upon me for support.

<u>Dependent(s) Information</u>	Date of Birth	Relationship to Insured	Gender	Full time Student	Disabled Dependent
<i>If there are more than four dependants, please attach a separate list.</i>					
last name _____ first name _____ middle initial _____	(day / month / year) _____	_____	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
last name _____ first name _____ middle initial _____	(day / month / year) _____	_____	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
last name _____ first name _____ middle initial _____	(day / month / year) _____	_____	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**GROUP OR EMPLOYER:** \_\_\_\_\_

Plan Member's name: \_\_\_\_\_

Date: \_\_\_\_\_

**CHANGE IN BENEFICIARY – HEALTH AND WELFARE PLAN**

I hereby revoke all previous beneficiary designations and appoint the following revocable beneficiary(ies) of any Life benefits payable under the Health and Welfare Plan upon my death, and discharge the Trustees of the Plan to the extent of such payment. (Note: Your designation of a beneficiary will not be revoked or changed automatically by any future marriage or divorce. Should you wish to change your beneficiary in the event of a future marriage or divorce, you will have to do so by means of a new designation.) **If more than one beneficiary is named, total distribution of the benefits must equal 100%.**

Beneficiary's Name(s)			Percent allocated	Relationship to Plan Member
_____ last name	_____ first name	_____ middle initial	_____	_____
_____ last name	_____ first name	_____ middle initial	_____	_____
_____ last name	_____ first name	_____ middle initial	_____	_____

**Contingent beneficiary – or Secondary beneficiary** in the event the beneficiary(ies) dies before me, the life benefit set out in the Group Insurance plan is to be paid to:

_____ Name of contingent beneficiary	_____ Relationship to Plan Member
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**CHANGE IN BENEFICIARY – PENSION PLAN**

I hereby revoke all previous beneficiary designations and appoint the following revocable beneficiary(ies) of any Pension death benefits payable under The Pension Plan upon my death, and discharge the Trustees of the Plan to the extent of such payment. **If more than one beneficiary is named, total distribution of the benefits must equal 100%.** (Note: Your designation of a beneficiary will not be revoked or changed automatically by any future marriage or divorce. Should you wish to change your beneficiary in the event of a future marriage or divorce, you will have to do so by means of a new designation). **Under most pension jurisdictions, spousal rights override non-spousal beneficiary designations.** Please note, your spouse or common-law partner may elect to waive their rights to pre-retirement death benefits by completing the appropriate waiver form.

Beneficiary's Name(s)			Percent allocated	Relationship to Plan Member
_____ last name	_____ first name	_____ middle initial	_____	_____
_____ last name	_____ first name	_____ middle initial	_____	_____
_____ last name	_____ first name	_____ middle initial	_____	_____

**Contingent beneficiary – or Secondary beneficiary** in the event the beneficiary(ies) dies before me, the pension death benefit set out in the Pension Plan is to be paid to:

_____ Name of contingent beneficiary	_____ Relationship to Plan Member
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**TRUSTEE APPOINTMENT FOR HEALTH & WELFARE AND/OR PENSION PLAN**

If designating a beneficiary who is a minor (under age 18) or who lacks legal capacity to receive the proceeds, you **must** appoint a trustee/administrator. If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

_____ Trustee Name	_____ Relationship to plan member
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Signature of Plan Member: \_\_\_\_\_ Date: \_\_\_\_\_  
D / M / Y