

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)
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Part 2: Change in Family Status

Change of coverage requested due to the following "event": <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"/> Other (specify): _____	Date of Event (M/D/Y)
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Revised Extended Health Coverage <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)	Revised Dental Coverage <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)
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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 and student number if child is over 21 and studying full-time. If child is disabled, state nature of disability and attach details. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
<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: <input type="checkbox"/> Spouse's plan terminated – enroll on BCPSEA 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 BCPSEA plan by completing Waiver of Coverage Form. Spouse's policy number: _____	Date of Change (M/D/Y)
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Revised Extended Health Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)	Revised Dental Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived (attach Waiver of Coverage form)
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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	<input type="checkbox"/> Employee <input type="checkbox"/> 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) _____