

Group Insurance Policy Service Request

TO BE COMPLETED BY THE EMPLOYEE

First name _____ Last Name _____ Policy _____ Division _____ Certificate _____

A. CONTACT INFORMATION CHANGE	Address _____		City _____		Province _____		Postal Code _____	
	Telephone Number _____		() _____ - _____		() _____ - _____		() _____ - _____	
	Home		Office		Cell			
	E-mail _____							

B. CHANGE OF BENEFICIARY	PRIMARY BENEFICIARY						
	First Name _____	Last Name _____	Date of Birth (DD/MM/YYYY) _____	%	Revocable	Irrevocable	Relationship to employee
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
	Total (must be equal to 100%)						
	CONTINGENT BENEFICIARY						
	First Name _____	Last Name _____	Date of Birth (DD/MM/YYYY) _____	%	Revocable	Irrevocable	Relationship to employee
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
Total (must be equal to 100%)							

If the beneficiary is a minor, please designate a trustee: _____
 Relationship of the trustee to the employee: _____

Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocable, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary. In Quebec, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. The policy does not confer any rights to contingent beneficiaries prior to the death of the primary beneficiaries.

C. CHANGE OF NAME	Please be advised that my name has been changed to: _____	
	First Name _____	Last Name _____
	This change is effective on: ____/____/____ <small>DD MM YYYY</small>	Reason for name change: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other

Note: A name change due to a change in marital status may also require a change in dependent coverage. Please review section D. Please provide a copy of the driver's license, passport, birth certificate or marriage certificate.

D. DEPENDENT INFORMATION CHANGE	Change to: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Single-Parent* <input type="checkbox"/> Couple*		Effective date: ____/____/____ <small>DD MM YYYY</small>		
	<small>* If not provided under your contract, this will be considered as family coverage.</small>				
	Reason: <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Cohabitation		Date of marriage/ Cohabitation start date: ____/____/____ <small>DD MM YYYY</small>		
		First Name	Last Name	Gender	Date of Birth (DD/MM/YYYY)
	Spouse*: <input type="checkbox"/> Add <input type="checkbox"/> Remove			<input type="checkbox"/> M <input type="checkbox"/> F	
Children: <input type="checkbox"/> Add <input type="checkbox"/> Remove			<input type="checkbox"/> M <input type="checkbox"/> F		
Children: <input type="checkbox"/> Add <input type="checkbox"/> Remove			<input type="checkbox"/> M <input type="checkbox"/> F		

* If spouse has other coverage, please review section E.

Employee's Signature

I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my knowledge and authorize the company to make the specified changes.

Employee's Signature _____ Date (DD/MM/YYYY) _____

TO BE COMPLETED BY THE EMPLOYEE

First name _____ Last Name _____ Policy _____ Division _____ Certificate _____

E. COORDINATION OF BENEFITS	Does your spouse have health coverage under his/her own insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ____/____/____ DD MM YYYY If yes, is the health coverage an/a: <input type="checkbox"/> Individual plan <input type="checkbox"/> Family plan Does your spouse have dental coverage under his/her own insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ____/____/____ DD MM YYYY If yes, is the dental coverage an/a: <input type="checkbox"/> Individual plan <input type="checkbox"/> Family plan Name of Spouse's Insurer: _____ Contract Number: _____
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F. REFUSAL OF HEALTH AND/OR DENTAL BENEFITS	Comment : All benefits under your group insurance plan are mandatory. However, you may waive the health and dental benefits if you have similar coverage under your spouse's plan. I understand the terms and conditions of the group insurance plan that is being offered, but I waive the following benefits: <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;"></td> <td style="text-align: center;">Myself and my dependents</td> <td style="text-align: center;">My dependents</td> </tr> <tr> <td>Effective Date: ____/____/____ DD MM YYYY</td> <td style="text-align: center;">Health Insurance <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td style="text-align: center;">Dental Insurance <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>If coverage under your spouse's plan is discontinued, you will have 31-day period in which to submit an application for coverage. After this date, you and your dependents must submit proof acceptable to Assumption Life in order to be covered. Upon approval of your membership, if need be, the dental insurance will be limited.</p> Name of Spouse's Insurer: _____ Contract Number: _____		Myself and my dependents	My dependents	Effective Date: ____/____/____ DD MM YYYY	Health Insurance <input type="checkbox"/>	<input type="checkbox"/>		Dental Insurance <input type="checkbox"/>	<input type="checkbox"/>
	Myself and my dependents	My dependents								
Effective Date: ____/____/____ DD MM YYYY	Health Insurance <input type="checkbox"/>	<input type="checkbox"/>								
	Dental Insurance <input type="checkbox"/>	<input type="checkbox"/>								

Employee's Signature
 I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my knowledge and authorize the company to make the specified changes.

 Employee's Signature _____
Date (DD/MM/YYYY)

TO BE COMPLETED BY THE EMPLOYER

G. SALARY CHANGE	Salary \$ _____ <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> yearly Effective date (DD/MM/YYYY) ____/____/____
H. TERMINATION OF COVERAGE	Please cancel the insurance of the above-mentioned employee as of ____/____/____. Reason <input type="checkbox"/> Termination of employment <input type="checkbox"/> Temporary layoff <input type="checkbox"/> Other (specify) _____
I. RETURN TO WORK	Employee has resumed duties as of (DD/MM/YYYY) ____/____/____.

Employer's Signature
 I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my knowledge and authorize the company to make the specified changes.

 Employer's Signature _____
Date (DD/MM/YYYY)