Change form

COMPLETE THIS FORM TO NOTIFY OF A CHANGE

MORNEAU SHEPELL

- **Sections 1 and 3 to 6 to be completed by plan sponsor/employer in ink.**
- **Sections 2 and 7 to 13 to be completed by plan member/employee in ink.**
- **Section 13 to be signed by plan member/employee and plan administrator in ink.**
- **For sections 3 to 13, please complete only the section that relates to your change.**
- **Return the ORIGINAL to the plan sponsor/employer.**
- **Return a COPY to: (Mail) Morneau Shepell, 895 Don Mills Road, CPAG, Toronto ON M3C 1W3 or (Fax) 1.877.464.0109.**

1 Plan Sponsor/Employer Information

Client name	Client/division code	Class	Insurance company name(s) A)
Policy/group contract numbers	Cost centre (if applicable)	Effective date of change D D / M M / Y Y Y Y	B)

2 Plan Member/Employee Information

Last name	First name	Middle initial	Marital status	Plan member ID #

3 Employment Status Change

Current employment status ◯ Full time ◯ Part time ◯ Seasonal/contract ◯ Terminated	**Effective:** D D / M M / Y Y Y Y	Hours worked per week
New employment status ◯ **Full time** ◯ **Part time** ◯ **Seasonal/contract** ◯ **Terminated**	**Effective:** D D / M M / Y Y Y Y	**Hours to be worked per week**

4 Salary Change

Current annual salary	**New annual salary**

5 Division Transfer

Current division	**New division**

6 Class Change

Current class	**New class**

7 Birth Date Correction

◯ Employee ◯ Spouse ◯ Dependant	Current birth date D D / M M / Y Y Y Y **New birth date** D D / M M / Y Y Y Y

8 Name Change

◯ Employee ◯ Spouse ◯ Dependant	Current last name	Current first name	Current middle initial
	New last name	**New first name**	**New middle initial**

9 Address Change

Current mailing address			**New mailing address**		
City	Province	Postal code	**City**	**Province**	**Postal code**

10 Coverage Change

Health ◯ Single ◯ Couple ◯ Family	Dental ◯ Single ◯ Couple ◯ Family	Effective: D D / M M / Y Y Y Y

11 Add or Delete a Dependant

◯ **Add** ◯ **Delete** Spouse's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender ◯ M ◯ F	
◯ **Add** ◯ **Delete** Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender ◯ M ◯ F	Student ◯ Yes ◯ No
◯ **Add** ◯ **Delete** Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender ◯ M ◯ F	Student ◯ Yes ◯ No

Reason:

12 Beneficiary Change

If you designate a beneficiary who is:

(a) under the age of majority, or

(b) mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

*If you are a Quebec resident and you designate your spouse as a beneficiary, you are not permitted to change that beneficiary unless you:

(a) indicate that your designation of beneficiary is revocable, by checking the box on this form, or

(b) your spouse agrees, in writing, to be removed as your beneficiary.

**If you are a resident of a province other than Quebec, your beneficiary designation is automatically revocable unless you specifically make it irrevocable. If you make an irrevocable beneficiary designation, you will not be able to alter or change your beneficiary designation in any way without the consent of the beneficiary. If your beneficiary is a minor, you will not be permitted to alter or change your beneficiary designation in any way until your beneficiary reaches the age of majority. You should consider obtaining legal and financial advice from a professional advisor before making any irrevocable beneficiary designation.

Original beneficiary information will be kept by your plan sponsor/employer.

Name Your Beneficiary or Beneficiaries

Name of Beneficiary (last/first/middle)	Relationship to Plan Member	Beneficiary Revocable?**	Percent Allocated
		◯ Yes ◯ No	%
		◯ Yes ◯ No	%
		◯ Yes ◯ No	%
		◯ Yes ◯ No	%
	Total value must equal 100%		**Total** 0 **%**

I appoint _____ as trustee to receive any amount designated to a beneficiary who is under the age of majority or mentally incapacitated.

In the event the primary beneficiary or beneficiaries predeceases the plan member, the following contingent beneficiary or beneficiaries shall be entitled to the benefits:

Name of Contingent Beneficiary (last/first/middle)	Relationship to Plan Member	Beneficiary Revocable?**	Percent Allocated
		◯ Yes ◯ No	%
		◯ Yes ◯ No	%

For Quebec residents only*

If you have designated your spouse as beneficiary, the designation will be irrevocable, unless you indicate that you wish it to be revocable below.

I wish to make my designation: ◯ Revocable ◯ Irrevocable

13 Plan Member/Employee Declaration

I consent to the collection, use, and exchange of my personal information by my plan sponsor/employer or the administrator, an insurance company, and/or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependant children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependant children over the age of majority, to share information as it relates to the plan.

I hereby apply for group benefits under my plan sponsor's/employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my plan sponsor/employer.

I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time.

Plan member/employee signature Date signed

Plan administrator signature Date signed