Public Education PEBT BENEFITS TRUST
Your benefits, your health

The appropriate section(s) below should only be completed as changes to the Benefits Enrolment Form are required. Once completed, the benefits administrator should file this form for future reference.

# Benefits Change Form

## Part 1: Employee Identification

| Employee's Last Name | First Name | Initial | District # | Employee ID number | Provincial Health Plan Number (Care Card) |
|---|---|---|---|---|---|
| | | | | | |

## Part 2: Change in Family Status

Change of coverage requested due to the following "event":

Date of Event (yyyy/mm/dd) YYYY MM DD

◯ Marriage ◯ Cohabitation ◯ Divorce ◯ Separation ◯ Death ◯ Birth ◯ Adoption ◯ Other (specify):

Revised Extended Health Care Coverage

◯ Single ◯ Couple ◯ Family ◯ Waived (attache Waiver of Coverage form)

Revised Dental Coverage

◯ Single ◯ Couple ◯ Family ◯ Waived (attached Waiver of Coverage form)

| Add | Delete | No. | Dependent's First Name | Initial | Last Name (if different from Employee) | Birthdate (yyyy/mm/dd) | Relationship | Gender<br>M – Male<br>F – Female<br>X – Another Gender<br>U – Prefer Not to Disclose | Provide name of school **and student number** if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document. |
|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | | | | | | | | |
| ◯ | ◯ | | | | | | | | |
| ◯ | ◯ | | | | | | | | |
| ◯ | ◯ | | | | | | | | |
| ◯ | ◯ | | | | | | | | |

## Part 3: Change to Spousal or Other Coverage

Change of ☐ Dental ☐ Extended Health coverage requested due to:

Date of Change (yyyy/mm/dd) YYYY MM DD

☐ Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)

☐ Transferring to Spouse's plan - terminate from PEBT plan by completing Waiver of Coverage Form. Spouse's policy number: _____

Revised Extended Health Coverage:

☐ Single ☐ Couple ☐ Family ☐ Waived (attach Waiver of Coverage form)

Revised Dental Coverage:

☐ Single ☐ Couple ☐ Family ☐ Waived (attach Waiver of Coverage form)

## 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 (yyyy/mm/dd) YYYY MM DD |
|---|---|---|---|
| | | | |
| **New Last Name** | **First Name** | **Initial** | ☐ Employee<br>☐ Dependent |
| | | | |

I hereby confirm the above information is complete, true and correct. I understand that if this application is completed more than 31 days after the loss of extended health and/or dental coverage through another plan, or 4 months after the addition of an eligible dependent that changes my family status, satisfactory evidence of insurability will be required to add dependents to this plan. I reserve the right to change my beneficiary at any time.

Employee Signature _____ Date Signed (yyyy/mm/dd)_____