

The appropriate section(s) below should only be completed as changes to the Benefits Enrollment 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)	
<input type="radio"/> Marriage <input type="radio"/> Cohabitation <input type="radio"/> Divorce <input type="radio"/> Separation <input type="radio"/> Death <input type="radio"/> Birth <input type="radio"/> Adoption <input type="radio"/> Other (specify):								YYYY MM DD	
Revised Extended Health Care Coverage					Revised Dental Coverage				
<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attache Waiver of Coverage form)					<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> 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 M – Male F – Female X – Another Gender 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.
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
Part 3: Change to Spousal or Other Coverage									
Change of <input type="radio"/> Dental <input type="radio"/> Extended Health coverage requested due to:								Date of Change (yyyy/mm/dd)	
<input type="radio"/> Spouse's plan terminated – enroll on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)								YYYY MM DD	
<input type="radio"/> Transferring to Spouse's plan - terminate from PEBT plan by completing Waiver of Coverage Form. Spouse's policy number: _____									
Revised Extended Health Coverage:					Revised Dental Coverage:				
<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)					<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> 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? <input type="radio"/> All applicable benefits, or: <input type="radio"/> Basic Life <input type="radio"/> Optional Life <input type="radio"/> Basic AD&D <input type="radio"/> 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				<input type="radio"/> Employee <input type="radio"/> 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) _____