# CHANGE IN STATUS/BENEFICIARY/NAME

| Group # | Division | Class | Certificate # | Name of Employer | Employee Surname / First Name |
|---|---|---|---|---|---|
| | | | | | |

***You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.***
***In order to process your request, this form must be dated and signed.***

## STATUS CHANGE REQUEST

☐ Single to Family ☐ Family to Single ☐ No Change ☐ Nil to Single ☐ Nil to Family

* If you and/or your dependents are electing to waive health and/or dental coverage, please complete the opt-out section below.

**CHANGE DUE TO:**

☐ Marriage (date of marriage) _____
complete dependent information below

☐ Birth of Child - complete dependent information below

☐ Common-law spouse (date co-habitation began) _____
complete dependent information below

☐ Children of Common-law Spouse
List all eligible dependents below.
Do the children reside with you? ☐ Yes ☐ No

☐ Separation (date of separation) _____
Are children still to be covered under your policy? ☐ Yes ☐ No
Is spouse still to be covered under your policy? ☐ Yes ☐ No
Are you legally obligated to provide these benefits? ☐ Yes ☐ No
If yes, please provide copy of legal agreement or court order

☐ Divorce (date of divorce) _____
Are children still to be covered under your policy? ☐ Yes ☐ No
Is spouse still to be covered under your policy? ☐ Yes ☐ No
Are you legally obligated to provide these benefits? ☐ Yes ☐ No
If yes, please provide copy of legal agreement or court order

☐ Death of Dependent (date of death) _____
Relationship to Employee _____

## PREVIOUSLY WAIVED BENEFITS

REQUESTED CHANGE: ☐ Nil to Family ☐ Nil to Single ☐ Single to Family **Please list all eligible dependents below.**
APPLICABLE BENEFITS: ☐ Health ☐ Dental

☐ I hereby apply to participate in the Health and/or Dental benefits that were previously refused due to the existence of comparable coverage.
My comparable coverage terminated on _____ Previous Insurance Carrier _____

☐ Duplication of coverage – spousal coverage in place.

## ELIGIBLE DEPENDENT INFORMATION

| Name (state surname if different than yours) | Date of Birth (yy/mm/dd) | Name (state surname if different than yours) | Relationship to Employee | Date of Birth (yy/mm/dd) |
|---|---|---|---|---|
| Spouse | | Children* | | |
| | | | | |
| | | | | |
| | | | | |

Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.

*Children of common-law spouses must reside with the employee to be eligible.

## WAIVE/OPT-OUT OF EXTENDED HEALTH CARE AND/OR DENTAL BENEFITS

REQUESTED CHANGE: ☐ Family to Single ☐ Family to Exempt ☐ Single to Exempt

I certify that I have been given the opportunity to participate in my employer's insurance plan. Comparable coverage is currently provided to me and/or my dependents under another group plan. Because of these existing benefits, I am declining coverage as indicated: Check option A or B, but not both.

**A – Employee and Dependent(s)** ☐ Health ☐ Dental **B – Dependent(s) only** ☐ Health ☐ Dental

My spouse is employed by _____ Insured by (carrier) _____

Spousal Coverage commenced on (date) _____

I understand that if I cease to be covered under my spouse's plan and I wish to participate in the benefits hereby declined, I must complete the Previously Waived Benefits section of this form within 31 days of loss of coverage. If I do not apply within 31 days, I must submit evidence of insurability satisfactory to the Insurance Company which may be at my own expense. Dental coverage, if applicable, will be limited to $250 per individual for the first year of coverage.

## EMPLOYEE NAME CHANGE

New Legal Surname _____ First Name _____

## BENEFICIARY CHANGE - original signed form must be submitted

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to appoint contingent beneficiaries.

**Beneficiary(ies) ***

| Name(s) (first, middle initial, last) | Relationship to Employee | % Share (must = 100%) |
|---|---|---|
| | | % |
| | | % |
| | | % |

**Trustee** ***If a beneficiary is under age 18**: Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

| Trustee Name (first, middle initial, last) | As Trustee for (beneficiary name) | Relationship to Beneficiary |
|---|---|---|
| | | |

*Witness must be over 18 and not be a beneficiary*

Witness (Signature) X _____ Date _____

**Authorization:** I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by me.

**Employee's Signature X** _____ **Date** _____