

**GROUP INSURANCE
CHANGE CARD**



Benefit plans administered by:
D.A. TOWNLEY
& ASSOCIATES LTD.
www.datownley.com

EMPLOYER NAME _____	POLICY # _____
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EMPLOYEE'S SURNAME _____	FIRST NAME _____	INITIAL _____	SOCIAL INSURANCE NUMBER _____	IS THIS A NAME CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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ADDITION/DELETION OF DEPENDENTS OR DEPENDENT NAME CHANGE

INDICATE: A (ADD DEPENDENT) D (DELETE DEPENDENT) N (NAME CHANGE)	DEPENDENT'S FIRST NAME	SURNAME (IF DIFFERENT FROM EMPLOYEE)	DEPENDENT'S RELATIONSHIP TO EMPLOYEE	DEPENDENT BIRTHDATE Yr. Mo. Day	EFFECTIVE DATE (IF APPLICABLE) Yr. Mo. Day	TERMINATION DATE (IF APPLICABLE) Yr. Mo. Day
A D N						
A D N						
A D N						

CO-ORDINATION OF BENEFITS:

Are you covered by another benefit plan (i.e., your Spouse's plan)? NO YES
 If YES, benefits covered _____, Spouse's SIN: _____
 Policy No (s) _____ Insurance Carrier: _____
If you or your dependents do not require all benefits, you must complete the waiver on the reverse side of this card.

If adding a Spouse, date of marriage: _____
 If adding a Common-Law Spouse, date of commencement of Common-Law relationship: _____
 If adding children over the age of 19, indicate school they are attending full-time: _____

REVISED BENEFICIARY DESIGNATION:

LIFE INSURANCE: I hereby designate _____ (if living, otherwise my estate) as revocable beneficiary of any insurance payable in the event of my death, under the terms of the contract. Beneficiary relationship: _____
NOTE: If beneficiary is an underage child, please name an adult "in Trust for" the child.
OPTIONAL LIFE INSURANCE (if applicable): I hereby designate _____ (if living, otherwise my estate) as revocable beneficiary of any insurance payable in the event of my death, under the terms of the contract. Beneficiary relationship: _____

I authorize the use of my Social Insurance Number for identification purposes. I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits; to determine the cost and financially manage these benefits as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. This information may be released to the insurer(s) when necessary to provide benefits.

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____

**GROUP INSURANCE
BENEFIT CHANGES**

EMPLOYER _____	POLICY # _____	PHARMACARE REGISTRATION NO. _____
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EMPLOYEE'S NAME _____	S.I.N./I.D. # _____
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- Application for: Dental For: Myself and/or
 Deletion of: Extended Health Benefits (may include Vision Care under some plans) My Dependents
 Other (specify) _____

REASON FOR Addition of Benefits:

OR Deletion of Benefits:

<input type="checkbox"/> Comparable coverage has been provided under my Spouse's plan. Date alternate coverage ceased _____ <input type="checkbox"/> Coverage was previously waived as it was optional and I did not wish to participate. Coverage is now requested. I have included the required evidence of insurability forms. I understand that the insurance company must approve my application and advise me of the effective date. I also understand that some benefit limitations may apply.	<input type="checkbox"/> Comparable coverage is provided under my Spouse's plan. This alternate coverage is effective: _____ <input type="checkbox"/> If coverage is optional, I do not wish to participate. I agree that if at a later date I wish to participate in the insurance hereby refused, I must submit, at my own expense, evidence of insurability for myself and any dependents for whom application for coverage is made. However, if I have refused Health/Dental coverage because of other group coverage, such evidence of insurability will not be required provided the alternate coverage terminates and I apply for Health Insurance within 31 days of the termination date.
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EMPLOYEE'S SIGNATURE: _____ **DATE:** _____