BASIC HEALTH AND WELFARE PLAN

GROUP INSURANCE CHANGE FORM- BASIC HOUR BANK PLAN

- **Parts 1 and 5 must be completed for all changes**. All changes should be submitted within 31 days of the date of event. To submit, MAIL the ORIGINAL completed form to **D.A. Townley & Associates, #101 – 4190 Lougheed Highway, Burnaby, B.C., V5C 6A8**. You can fax the form for immediate processing to (604) 299-8136,, but the original must follow.
- Keep a copy of this form with the plan member's personnel file.

Reason for Completion: complete Parts 1 and 5 plus any other additional sections indicated

❐ Change in Family Status/ Spousal Coverage (Part 2)	❐ Change of Beneficiary Designation (Part 3)	❐ Change of Name (Part 4)	❐ Termination	If Terminatins, Date of Change (M/D/Y)

Part 1: Employee Identification (PLEASE COMPLETE IN FULL)

Employer Group Name	Account/Billing #	EHC Group #	Dental Group #
	29243	**29243**	**29243**

Employee's Last Name	First Name	Initial	Phone Number	SIN

Mailing Address	Birthdate (M/D/Y)	Gender ❐ Male ❐ Female

Part 2: Change in Family Status or Spousal Coverage

Change of coverage requested due to the following "life event": ❐ Marriage ❐ Cohabitation (12 mos) ❐ Divorce ❐ Separation ❐ Death ❐ Birth | Date of Event (M/D/Y)

Revised Extended Health Coverage ❐ Single ❐ Family | Revised Dental Coverage ❐ Single ❐ Family

Add (Mark with an "X")	Cancel	Dep. No.	Dependent's Last Name (if different from Employee)	Initial	First Name	Birthdate (M/D/Y)	Relationship	Gender (M/F)	Provide name of school below if child is over 19 and studying full time. If child is disabled to apply for coverage beyond age 19, indicate nature of disability and attach details.

Coordination of Benefits (COB) Information – Other Plan Details: ►	Spouse's Carrier(s)	Spouse's Group #(s)	Spouse's Certificate/ID #

Part 3: Change of Beneficiary Designation

New Beneficiary - Last Name	First Name	Initial	Share of Proceeds	Relationship to Employee	Name of Trustee for Beneficiaries Under the Age of Majority (18 in B.C.)
			%		
			%		

Part 4: Change of Name

Previous Last Name	First Name	Initial	Date of Change (M/D/Y)

Also apply this change to my dependent:: ❐ Spouse ❐ Children

Part 5: Authorization - If the above changes include a change to my beneficiary, 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. I also understand that on the date the insurance of my dependent(s) becomes effective (if applicable) that they cannot be confined to hospital. I authorize the use of my Social Insurance Number for identification purposes.

I certify that the information given above is complete, true and correct.

Employee Signature: ______________________________Date Signed (M / D / Y) ____________________

Authorized Signature (Plan Administrator) ______________________________ Date Signed (M / D / Y) ____________________