



PREMIUM HEALTH AND WELFARE PLAN

GROUP INSURANCE CHANGE FORM - PREMIUM 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 Terminates, Date of Change (M/D/Y)

Part 1: Employee Identification (PLEASE COMPLETE IN FULL)

Employer Group Name Account/Billing # 49243 EHC Group # 49243 Dental Group # 49243 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

Table with columns: Add, Cancel, Dep. No., Dependent's Last Name, 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.

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)