BC CONSTRUCTION ASSOCIATION
Employee Benefit Program

Built for you.

Please send original and signed copy to:
DA TOWNLEY

HOURBANK PLAN CHANGE FORM – POLCY 49243

GROUP INSURANCE CHANGES

Part 1 must be completed for all changes. All changes should be submitted 31 days of the date of the event.
- To submit, MAIL the ORIGINAL completed form to the BCCA Group Benefit Plan office. You can fax the form for immediate processing, but the original must follow.
- Keep a copy of this form with the plan member's personnel file.

Reason for completion

☐ Terminate Plan Member (Part 1) ☐ Change in Family Status (Part 2 and Part 3) ☐ Change to Spousal or Other Coverage (Part 3)
☐ Change of Beneficiary Designation (Part 4) ☐ Change of Name (Part 2, Part 3 and Part 5) ☐ Change of Mailing Address (Part 6)

Part 1: Employee Identification

BCCA Employer Group Name	Account/Billing# 49243	Division# (if applicable)	Class (if applicable)

Employee's Last Name	First Name	Initial	SIN	If Terminated, Date of Change (M/D/Y)
				| |

Part 2: Change in Family Status

Change of coverage requested due to the following "life event": **Date of Event (M/D/Y)** \| \|

☐ Marriage ☐ Cohabitation* ☐ Divorce ☐ Separation ☐ Death ☐ Birth ☐ Other (specify) _____

*please state the start date of cohabitation (requirement of 12 months of cohabitation)

Revised Extended Health Coverage ☐ Single ☐ Family

Revised Dental Coverage ☐ Single ☐ Family

Add	Cancel	Dep. No.	Dependent's Last Name (if different from Employee)	First Name	Initial	Birthdate (M/D/Y)	Relationship	Sex (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.
☐	☐	☐							
☐	☐	☐							
☐	☐	☐							
☐	☐	☐							

Part 3: Change to Spousal or Other Coverage

Change request for ☐ **Extended Heath** ☐ **Dental coverage due to:** **Date of Event (M/D/Y)** \| \|

☐ Addition of spouse: Spouse has coverage on his/her employer's plan – Date of Change should match the Date of Event in Part 2
☐ Transferring to Spouse's plan – Date of Change should be the date the Spouse's plan went into effect
☐ Spouse's plan terminated – Date of Change should be the date the Spouse's plan terminated

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

Revised Extended Health Coverage ☐ Single ☐ Family ☐ Waive

Revised Dental Coverage ☐ Single ☐ Family ☐ Waive

Part 4: Change of Beneficiary Designation

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.)	If a resident of Quebec (please indicate)
						☐ Revocable ☐ Irrevocable
						☐ Revocable ☐ Irrevocable
						☐ Revocable ☐ Irrevocable

To which benefit (s) does this change apply (if applicable to your group)? Basic Life Optional Life Voluntary AD&D (note beneficiary for basic, AD&D is same as for basic life insurance)

Part 5: Change of Name

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

New Last Name	First Name	Initial	
			☐ Employee ☐ Spouse ☐ Dependent Child

Part 6: Change of Employee's Mailing Address

Apt/Unit Number	Street (Mailing) Address	Date of Change (M/D/Y)
		| |

City	Province	Postal Code	Phone Number

Part 7: Authorization – I hereby confirm the above information is complete, true and correct.

Where/If used, I authorize the use of my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.

Employee Signature_____ Date Signed (M/D/Y)_____/_____/_____

Authorized Signature_____ Date Signed (M/D/Y)_____/_ _/_____