GROUP CHANGE FORM – INSURED EMPLOYEE CHANGES

Throughout this form "Empire Life" means The Empire Life Insurance Company.

To be completed by the Insured Employee

Reset Form

1.	Name of Employer/Division	Group number	Division number	Certificate number
	Employee first name	Last name		

2. TYPE OF CHANGE REQUESTED

Select the type of change and indicate the corresponding letter in the "Type of Change" column below.

A) Change Employee's Name or Address (Complete Sections 3 & 8.)
B) Banking Information (Complete Sections 4 and 8.)
C) Change in Dependant coverage (Include reasons in the Comments section below and complete Sections 5 & 8.)
D) Waiver of Benefits, Coordination of Benefits or Total Refusal of Benefits (Employee to read and complete Sections 6 & 8.)
E) Change of Beneficiary Designation (Employee to complete Sections 7 & 8.)
F) Other (Provide details in Comments section and complete Section 8.)

Type of change (indicate letter above)	**Effective date** (dd/mmm/yy)	**Comments** (provide details - if more space is required, attach a separate sheet.)

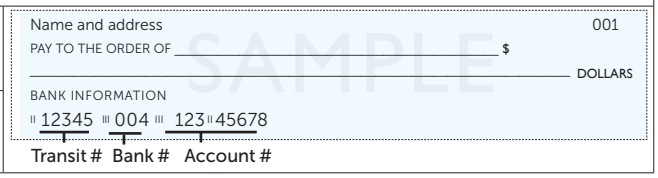
3. CHANGE EMPLOYEE'S NAME OR ADDRESS – ◯ Name change ◯ Address change

New first name (PRINT in full)	Last name (PRINT in full)	
Reason for name change		Effective date (dd/mmm/yy)
New address (number, street name)		
City	Province	Postal code

4. BANKING INFORMATION – ◯ I would like electronic deposit of Health and Dental claim payments into my bank account.

Please attach a personalized void cheque in the name of the Employee or complete the banking information below:

Bank name		
Transit number	Bank number	Account number



5. CHANGE IN DEPENDANT INFORMATION (Complete if you are adding or removing a dependant, or updating dependant information.)

Effective date (dd/mmm/yy)	**Change your plan to:** ◯ Single ◯ Family ◯ Waived

Do your spouse/dependants have a provincial health card (e.g. OHIP, MSP, RAMQ)? ◯ yes ◯ no

Reason for change: ◯ Birth/adoption of child ◯ Separation ◯ Marriage ◯ Cohabitation ◯ Loss of coverage (dd/mmm/yy):	Date of marriage/start of cohabitation: (dd/mmm/yy)

List spouse/child information below. If more space is required, attach a separate sheet.

First name	Last name	Relationship (spouse, child)	Date of birth (dd/mmm/yy)	Gender (M/F/X)	Disabled Child*	Full-time student age 22 and older**	Change Type
					◯ yes	◯ yes	◯ add ◯ remove
					◯ yes	◯ yes	◯ add ◯ remove
					◯ yes	◯ yes	◯ add ◯ remove
					◯ yes	◯ yes	◯ add ◯ remove

*Complete the Disabled Child Dependant form and submit with the Group Enrolment Form.
Complete student information below – **Note: The student must be attending an accredited school, on a full time basis. If more than one student, attach a separate sheet.

First name	Last name

Term start date (dd/mmm/yy)	Term end date (dd/mmm/yy)	Has Provincial Health Care been extended? ◯ yes ◯ no

Post-secondary School name	If located outside Canada or U.S, specify country

6. WAIVER OR COORDINATION OF BENEFITS

Understanding your choice

- I acknowledge that I have been offered the benefits of my Employer's Group Insurance Plan with The Empire Life Insurance Company and benefits provided by this Plan have been fully explained to me.
- I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits.
- I understand that if I apply for refused/waived coverage in the future, I may be required to provide evidence of insurability at my own expense.
- **If waiver is not selected, family coverage will be applied.**

Do you or any other member of your family have extended health or dental benefits with another plan? ◯ **yes** ◯ **no**
If yes, specify if other coverage is ◯ single coverage ◯ family coverage

Waiver of benefits
If you or your dependants are presently covered for extended health and/or dental benefits under another plan, you may waive such benefits under this contract by selecting the applicable box for each benefit:
◯ I waive coverage for myself and my dependants under: ◯ Extended Health ◯ Dental
◯ I waive coverage for my dependants only under: ◯ Extended Health ◯ Dental
Name of other Insurer _____

Coordination of benefits
I wish to coordinate benefits coverage with my spouse's carrier **and** family coverage with Empire Life under:
◯ Extended Health ◯ Dental

Total Refusal of ALL Benefits (non-mandatory plans only)
◯ I waive all coverage for me and my dependants

7. BENEFICIARY DESIGNATION (TO BE USED ONLY FOR BENEFITS PAYABLE UPON DEATH OF INSURED EMPLOYEE)

Minors:

Death benefits will not be paid directly to a minor beneficiary. Outside Quebec, you should name a trustee for a minor beneficiary and any death benefits due to the beneficiary, while a minor, will be paid to the trustee on their behalf. In Quebec, death benefits due to a beneficiary, while a minor, will be paid to the their parent(s) or legal guardian unless you have established a formal trust. After the beneficiary reaches the age of majority, any death benefits due to the beneficiary will be paid directly to the beneficiary unless you have established a formal trust and such trust is still in effect at the time the death benefit is due.

Primary Designations:

- If a beneficiary is not named, the death benefit will be paid to the Estate of the Employee.
- Percentages for all primary beneficiaries must total 100%.
- If you name more than one beneficiary and do not indicate a share percentage, the death benefits will be divided equally among all surviving beneficiaries.
- You may change this beneficiary designation at any time upon written notice to Empire Life.
- If you wish to make the beneficiary designation irrevocable (meaning you can not change the designation or make changes to your coverage under the plan without the written consent of the beneficiary), please complete the applicable beneficiary change form.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "revocable" below.
I hereby make the beneficiary designation: ◯ revocable - I may change this beneficiary designation at any time.

Primary Beneficiary(ies)

First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)

Contingent Beneficiary(ies)

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy, if all of the primary beneficiaries named, should die before you. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your Estate. Percentages for all contingent beneficiaries must total 100%.

First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)
First name	Middle initial	Last name	Relationship	
Date of birth (if minor) (dd/mmm/yy)		Trustee name (required if beneficiary is a minor)		Share (%)

8. DECLARATION, AUTHORIZATION AND SIGNATURES

By signing below I hereby revoke:

- any former beneficiary designation if changing beneficiary(ies) and direct that any proceeds be paid to the beneficiary(ies) named above.

I authorize:

- The Empire Life Insurance Company (Empire Life) to carry out the above-mentioned transaction(s) in keeping with the rights, terms and conditions of the Policy/Contract.
- Empire Life to deposit Health and Dental claim payments into my bank account as indicated in Section 4.

A photocopy or electronic copy of this change form and authorization will be as valid as the original.

Employee Signature **X**	Date signed (dd/mmm/yy)
Signature of Irrevocable Beneficiary(ies) (if applicable). **I hereby give my consent to the above change of beneficiary and relinquish my rights as beneficiary.** **X**	Date signed (dd/mmm/yy)
Plan Administrator Signature (not required for change of Beneficiary designation or banking information) **X**	Date signed (dd/mmm/yy)

Please return to:

Empire Life
Group Administration
259 King Street East Kingston, ON K7L 3A8
Group Customer Service: 1 800-267-0215 Fax: 1-888-841-9145
Email: group.administration@empire.ca