GROUP CHANGE FORM – INSURED EMPLOYEE CHANGES

To be completed by the Insured Employee

Reset Form

1.			
	Policyowner (Company name)	Group number	Division number
	Insured Employee		Certificate number

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) Change in Dependant coverage (Include reasons in the Comments section below and complete Sections 4 & 8.)
C) Banking Information (Complete Sections 5 and 8.)
D) Coverage Refusal or Waiver/notice for Coordination 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.)

If more space is required, attach a separate sheet.

Type of change (indicate letter above)	**Effective date** (dd/mmm/yy)	**Comments** (provide details of change)

3. Change Employee's Name or Address

◯ Change name ◯ Change address	Effective date (dd/mmm/yy):		
New name (PRINT in full)	Reason for name change	If marriage, provide date of marriage (dd/mmm/yy)	
Old address (number, street name)	City	Province	Postal code
New address (number, street name)	City	Province	Postal code

4. Change in Dependant Information (Complete if you are adding or removing a dependant, or updating dependant information.)

Effective date (dd/mmm/yy)	**Change to:** ◯ Single ◯ Family	Do your spouse/dependants have a provincial health card? (e.g. OHIP, MSP) ◯ yes ◯ no
Reason for change: ◯ Birth/adoption of child ◯ Divorce ◯ Marriage ◯ Cohabitation		Date of marriage/start of cohabitation: (dd/mmm/yy)

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

First name	Last name	Relationship (spouse, child)	Date of birth (dd/mmm/yy)	Gender (M/F)	Infirm dependant age 22 and older*	Full-time student age 22 and older **
					◯ yes	◯ yes
					◯ yes	◯ yes
					◯ yes	◯ yes

***Complete Overage Infirm Form and submit with Group Change Form.**

****Complete Full-time Post-secondary Student Information below.** 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)
Post-secondary School name	If outside Canada or USA, provide country name	Has Provincial Health Care been extended? ◯ yes ◯ no	

5. Banking Information – ATTACH A VOID CHEQUE (Cheque must be typeset with your name)

◯ I would like electronic deposit of Health and Dental claim payments into my bank account

Empire Life

6. Coverage Refusal or Waiver/Notice for Coordination of Benefits

Understanding the 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.

Total Refusal of ALL Coverage (non-Mandatory Plans only) See your Plan Administrator for details.

◯ I waive all coverage for me and my dependants, if any.

Waiver of Extended Health and/or Dental Coverage (Spousal Opt Out) OR notice of Co-ordination of Benefits
Only available if Spouse has coverage with another insurer. Name of other insurer must be provided, otherwise, Family Coverage will be provided.

◯ I, and/or my dependants, have coverage with my spouse's Group Insurance Plan and I wish to waive the following coverage **OR** Co-ordinate Benefits. **Complete the following information in full.**

Other Insurer Information:			**Select One Option:**		
	Name of other Insurer (spouse's plan)	Coverage type (single or family)	Waive coverage for myself & my dependants	Waive coverage for my dependants only	Co-ordination of Benefits
Extended Health			◯	◯	◯
Dental			◯	◯	◯

7. Change of Beneficiary Designation (to be used **only** for benefits payable upon death of Insured Employee)

Irrevocable/Revocable designations: A minor irrevocable beneficiary cannot consent to a change of beneficiary until the minor reaches the age of majority and a parent or guardian may not sign on behalf of a minor child for this purpose. All beneficiaries are assumed revocable unless you check the irrevocable box below, except in Quebec. In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless you check the revocable box.

Any irrevocable beneficiary must provide his/her consent for any changes below by signing in Section 8.

Minors: Outside Quebec, you should name a Trustee to receive the death benefits while the beneficiary is still a minor. In Quebec, the death benefits will be paid to the parent(s) or legal guardian unless you have established a formal Trust and such Trust is still in effect at the time the death benefit is due.

Multiple beneficiaries: Percentages for all 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. If more space is required, attach a hand-written letter including your signature.

I hereby revoke all previous beneficiary designations and designate the following:

Beneficiary

Name (First, Middle, Last)			Relationship
Share %	◯ Revocable ◯ Irrevocable	Date of birth (if minor) (dd/mmm/yy)	Trustee name
Name (First, Middle, Last)			Relationship
Share %	◯ Revocable ◯ Irrevocable	Date of birth (if minor) (dd/mmm/yy)	Trustee name

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 5.

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	
Signature of Plan Administrator (not required for change of Beneficiary designation or banking information) X	Date signed (dd/mmm/yy)