# Group Insurance Coverage Change Form
# for NSGEU, Confidential Excluded, Management

*Required (Note: form must be signed and dated on next page.)

*Reason for Change, e.g. marriage, common-law, divorce, widow(er), etc.: ___________________________

| *Marriage - date of marriage | *Common-law spouse - date of cohabitation | *Legal separation - date | *Widow(er) - Date of spouse's death | *Divorced - Date of divorce |
|---|---|---|---|---|
| | | | | |

*Effective Date of Coverage Change (dd/mm/yy)

| *Employee Name | *Employee ID |
|---|---|
| | |

**Health (indicate dependent information under Add/Delete/Change Dependent(s))**

**Change to** ___single coverage ___family coverage

___**Terminate coverage because I am covered under another health plan.

**Provide proof of new coverage, i.e. a letter from the administrator/insurer confirming: *Name of other insurer, Policy number, Date coverage effective, Type of coverage.*

If you are applying for health coverage as a result of losing coverage under another plan, you must provide proof of the loss: a letter from the administrator/insurer confirming: *Name of other insurer, Policy number, Date coverage ceases, Type of coverage lost, Reason coverage lost.* **Note: If you are adding or removing coverage due to another plan, no changes will be made until the letter is received.**
***Late applicant provisions will apply if this form & letter are not received within 31 days of the change date.***

**Dental (indicate dependent information under Add/Delete/Change Dependent(s))**

**Change to** ___single coverage ___family coverage

___**Terminate coverage because I am covered under another dental plan.

**Provide proof of new coverage, i.e. a letter from the administrator/insurer confirming: *Name of other insurer, Policy number, Date coverage effective, Type of coverage.*

If you are applying for dental coverage as a result of losing coverage under another plan, you must provide proof of the loss: a letter from the administrator/insurer confirming: *Name of other insurer, Policy number, Date coverage ceases, Type of coverage lost, Reason coverage lost.* **Note: If you are adding or removing coverage due to another plan, no changes will be made until the letter is received.**
***Late applicant provisions will apply if this form & letter are not received within 31 days of the change date.***

**Add/Delete/Change Dependent(s)**

| Action* | Relationship | Last name, First Name and Initials | Sex (M/F) | Date of birth (d/m/y) | Dependent Status** |
|---|---|---|---|---|---|
| | Spouse | | | | |
| | | | | | |
| | Child | | | | |
| | Child | | | | |
| | Child | | | | |
| | Child | | | | |
| | Child | | | | |

*D-Delete, A-Add, C-Change **Child, Student (college/university), Disabled

Please indicate any other children on an additional form. If the dependent child is between 21 and 26, you must provide proof that your child is attending an accredited educational institution on a full-time basis. Acceptable proof includes a completed registration form that has been stamped “paid” by the university or college or a letter from the institution indicating your dependent has full-time student status for the coming year. Photocopies of student cards are not acceptable.

Capital Health

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**Optional Life Insurance for Myself**
__Terminate coverage effective (dd/mm/yy):_____________________________________
__Reduce coverage effective (dd/mm/yy):___________________ New Lower Amount:_____________________________
To add or increase coverage, the optional life application and medical evidence form must be completed.

**Optional Life Insurance for my Spouse**
__Terminate coverage effective (dd/mm/yy):_____________________________________
__Reduce coverage effective (dd/mm/yy):___________________ New Lower Amount:_____________________________
To add or increase coverage, the optional life application and medical evidence form must be completed.

**Dependent Life Insurance**
__Terminate coverage effective (dd/mm/yy):_____________________________________
__Add coverage

**Voluntary Accidental Death & Dismemberment Insurance**
__Terminate coverage effective (dd/mm/yy):_____________________________________
To add, decrease or increase coverage, a new voluntary AD&D form must be completed.

**Critical Choice Care for Myself**
__Terminate coverage effective (dd/mm/yy):_____________________________________
To add or increase coverage, the critical choice care enrollment card and application must be completed.

**Critical Choice Care for my Spouse**
__Terminate coverage effective (dd/mm/yy):_____________________________________
To add or increase coverage, the critical choice care enrollment card and application must be completed.

**Beneficiary Designation for Basic Life and Basic Accidental Death and Dismemberment Insurance**

**I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):**

Name of Trustee(s) if Beneficiary(ies) under age 18: ____________________________________________________

**New Beneficiary(ies)**

| Last Name and Full First Name | Percentage | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**If you are not survived by a living designated beneficiary, your life/AD&D insurance will be paid to your Estate.**

I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the policyholder's request. I authorize the policyholder to deduct from my earnings any required contribution for the insurance to which I am or may be entitled. I authorize the use of my Social Insurance Number for group insurance identification purposes and as required by law, for income tax reporting.

Signature of Employee ______________________ Date ______________________

Witness (Please Print) ______________________ Date ______________________

Witness Signature ______________________

IPS Data Entry Analyst ______________________ Date ______________________

**The original, signed form is legally required for changes to your beneficiary information.**
**Please ensure your beneficary does not act as your witness.**