CHANGE IN STATUS/BENEFICIARY/NAME

Group #	Division	Class	Certificate #	Name of Employer	Employee Surname First Name

In order to process your request, this form must be dated and signed.

STATUS CHANGE REQUEST

☐ Single to Family ☐ Family to Single ☐ No Change ☐ Nil to Single ☐ Nil to Family

* If you and/or your dependents are electing to waive health and/or dental coverage, please complete the opt-out section below.

CHANGE DUE TO:

☐ Marriage (date of marriage) _____
complete dependent information below

☐ Birth of Child - complete dependent information below

☐ Common-law spouse (date co-habitation began) _____
complete dependent information below

☐ Children of Common-law Spouse
List all eligible dependents below.
Do the children reside with you? ☐ Yes ☐ No

☐ Separation (date of separation) _____
Are children still to be covered under your policy? ☐ Yes ☐ No
Is spouse still to be covered under your policy? ☐ Yes ☐ No
Are you legally obligated to provide these benefits? ☐ Yes ☐ No
If yes, please provide copy of legal agreement or court order

☐ Divorce (date of divorce) _____
Are children still to be covered under your policy? ☐ Yes ☐ No
Is spouse still to be covered under your policy? ☐ Yes ☐ No
Are you legally obligated to provide these benefits? ☐ Yes ☐ No
If yes, please provide copy of legal agreement or court order

☐ Death of Dependent (date of death) _____
Relationship to Employee _____

PREVIOUSLY WAIVED BENEFITS

REQUESTED CHANGE: ☐ Nil to Family ☐ Nil to Single ☐ Single to Family **Please list all eligible dependents below.**
APPLICABLE BENEFITS: ☐ Health ☐ Dental

☐ I hereby apply to participate in the Health and/or Dental benefits that were previously refused due to the existence of comparable coverage.
My comparable coverage terminated on _____ Previous Insurance Carrier _____

☐ Duplication of coverage – spousal coverage in place.

ELIGIBLE DEPENDENT INFORMATION

	Name (state surname if different than yours)	Date of Birth (yy/mm/dd)		Name (state surname if different than yours)	Relationship to Employee	Date of Birth (yy/mm/dd)
Spouse			Children*			

Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.

*Children of common-law spouses must reside with the employee to be eligible.

WAIVE/OPT-OUT OF EXTENDED HEALTH CARE AND/OR DENTAL BENEFITS

REQUESTED CHANGE: ☐ Family to Single ☐ Family to Exempt ☐ Single to Exempt

I certify that I have been given the opportunity to participate in my employer's insurance plan. Comparable coverage is currently provided to me and/or my dependents under another group plan. Because of these existing benefits, I am declining coverage as indicated: Check option A or B, but not both.

A – Employee and Dependent(s) ☐ Health ☐ Dental **B – Dependent(s) only** ☐ Health ☐ Dental

My spouse is employed by _____ Insured by (carrier) _____

Spousal Coverage commenced on (date) _____

I understand that if I cease to be covered under my spouse's plan and I wish to participate in the benefits hereby declined, I must complete the Previously Waived Benefits section of this form within 31 days of loss of coverage. If I do not apply within 31 days, I must submit evidence of insurability satisfactory to the Insurance Company which may be at my own expense. Dental coverage, if applicable, will be limited to $250 per individual for the first year of coverage.

EMPLOYEE NAME CHANGE

New Legal Surname _____ First Name _____

BENEFICIARY CHANGE

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to appoint contingent beneficiaries.

Beneficiary(ies) *

Name(s) (first, middle initial, last)	Relationship to Employee	% Share (must = 100%)
		%
		%
		%

Trustee ***If a beneficiary is under age 18**: Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

Trustee Name (first, middle initial, last)	As Trustee for (beneficiary name)	Relationship to Beneficiary

Witness must be over 18 and not be a beneficiary

Witness (Signature) **X** _____ Date _____

Authorization: I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by me.

Employee's Signature X _____ **Date** _____