Sirius Benefits
Sirius Benefits is a People Corporation Company

MEMBER CHANGE REQUEST

All dates must be entered as DD/MM/YYYY.

Member: Please print clearly, completing all applicable sections and signing section 11. Pass this form onto your Plan Administrator.
Plan Administrator: Please review and sign this form prior to submitting to Sirius Benefit Plans.

1	**Group #:**		**Firm #:**		**Firm Name:**	
	Certificate #:		**Member Name:**			

2	**Member Address Change**	New Address	Effective Date (DD/MM/YYYY)

3	**Member Name Change**	Old Last Name	Old First Name	Reason for Change
		New Last Name	New First Name	Effective date of Change (DD/MM/YYYY)

4	**Marital Status Update**	Change status to: ☐ single ☐ married ☐ common-law ☐ separated ☐ divorced Date of co-habitation:	Date change occured (DD/MM/YYYY)

5	**Class Change**	Change Class to:	Reason for change:	Date change occured (DD/MM/YYYY)

6	**Addition of Benefits** If choosing to add coverage for dependents, you must list all dependents under #9	**Extended Health Care (EHC)** I wish to add EHC coverage for: ☐ myself ☐ my dependents ☐ myself and my dependents	**Dental Care** I wish to add Dental coverage for: ☐ myself ☐ my dependents ☐ myself and my dependents	**Dependent Life** ☐ I wish to add Dependent Life coverage
		Reason for addition of coverage: (i.e. If you lost coverage under a spouse's plan you must provide an explanation and indicate the date the coverage ceased).		

7	**Refusal of Benefits**	**You may only refuse coverage if you and/or your dependents are covered for similar benefits under your spouse's plan**	**Extended Health Care (EHC)** I do NOT want EHC coverage for: ☐ myself and my dependents ☐ my dependents only		**Dental Care** I do NOT want Dental coverage for: ☐ myself and my dependents ☐ my dependents only	
			Date coverage began under spouse's plan (DD/MM/YYYY)		Date coverage began under spouse's plan (DD/MM/YYYY)	
			Policy #		Policy #	
			Name of Group Insurer		Name of Group Insurer	

8	**Termination of all dependent coverage** This only applies if you no longer have dependents (spouse or children)	☐ I wish to terminate all coverage for all dependents ☐ I wish to terminate coverage for some of my dependents (must complete #9)	Effective date of termination (DD/MM/YYYY)	Reason for termination

9 Dependent Information

Please complete this section when changing information on existing dependents or adding /removing a dependent.
Ensure that you include your spouse when listing your dependents.

Change type code (see below)	Effective date of change (DD/MM/YYYY)	Name		Date of Birth (DD/MM/YYYY)	Sex M or F	Relationship	For over-age dependent children only see booklet for definitions of each	
		Last	First				Full-time University or College Student* Yes or No	Disabled Dependent* Yes or No ?

Change type codes:
A=add,
C= change
D= delete

***Please complete an overage dependent application if the dependent child is attending college or university (secondary education) or if you wish to submit your dependent child as an overage disabled dependent. Your booklet contains additional information.**

10 Beneficiary Change

Note: The effective date of the Beneficiary change is the date this form is signed.

I hereby revoke all prior beneficiary designations and now designate the person(s) named as my revocable beneficiary.
For Quebec residents only: The beneficiary is considered irrevocable unless you check here ☐ which then identifies that the beneficiary is revocable.

Name		Relationship to Member	Percentage (cannot exceed 100% in total)
Last	First & Middle Initial		
			%
			%

Trustee Designation

This section is to be completed only if the beneficiary designated above is under the age of majority

I hereby appoint_____as
Trustee to receive any amount due to any beneficiary under the age of 18.

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I acknowledge that the information provided is true and accurate. If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purpose of determining eligibility for benefits.

Member Signature		**Date Signed**	

12 Member Termination

Reason for termination:

☐ no longer employed ☐ laid-off ☐ maternity leave

☐ leave of absence (medical) ☐ leave of absence (personal)

Last day worked (DD/MM/YYYY)

13 Plan Administrator Signature

		Date Signed	

All changes are subject to the terms of the Group Contract(s) and any applicable legislation.