Plan member change request

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Sirius Benefits Sirius Benefits is a People Corporation Company

Plan member: Please print clearly, completing all applicable sections, and sign section 11. Submit this form to your plan administrator.
Plan administrator: Please review and sign this form prior to submitting to Sirius Benefits.

1	**Group no.**		**Firm no.**		**Firm name:**	
	Certificate no.			**Plan member name:**		

2	**Plan member address change**	New address	Effective date DD/MM/YYYY

3	**Plan member name change**	Previous name Last	First	Reason for change
		New name Last	First	Effective date of change DD/MM/YYYY

4	**Marital status update**	Change status to: ☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced Date of co-habitation: JJ/MM/AAAA	Date of change DD/MM/YYYY

5	**Class change**	Change class to:	Reason for change:	Date of change DD/MM/YYYY

6	**Addition of benefits** If choosing to add coverage for dependants, you must list all dependants under #9	**Extended Health Care (EHC)** I wish to add EHC coverage for: ☐ Myself ☐ My dependants ☐ Myself and my dependants	**Dental Care** I wish to add Dental coverage for: ☐ Myself ☐ My dependants ☐ Myself and my dependants	**Dependant 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 can refuse coverage only if you and/or your dependants are covered for similar benefits under your spouse's plan.**	**Extended Health Care (EHC)** I do **not** want EHC coverage for: ☐ Myself and my dependants ☐ My dependants only		**Dental Care** I do **not** want Dental coverage for: ☐ Myself and my dependants ☐ My dependants 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 dependant coverage** Only available if you no longer have dependants (spouse or children)	☐ I want to terminate all coverage for all dependants ☐ I want to terminate coverage for some of my dependants (must complete #9)	Effective date of termination DD/MM/YYYY	Reason for termination

9	**Dependant information**	Complete this section when adding or removing a dependant, or making changes to information relating to an existing dependant. Ensure that you include your spouse when listing your dependants.

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. Refer to your booklet for definitions.	
		Last	First				Full-time university or college student?* Yes or No	Disabled dependant* Yes or No?

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

*Please complete an overage dependant application if the dependent child is attending college or university (secondary education), or if you are enrolling him or her as an overage disabled dependant. Refer to 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 plan member	Percentage (cannot exceed 100% in total)
Last	First and middle initial		

Trustee designation

This section is to be completed only if the beneficiary designated above is under the age of majority.
Note: An appointment of a trustee is not available to Quebec residents.

I hereby appoint _____
as trustee to receive any amount due to any beneficiary under the age of 18.

11	I acknowledge that the information provided is true and accurate. If applying for benefits for my dependants, I am authorized to release information concerning my spouse and my dependants for the purpose of determining eligibility for benefits.			
	Plan member signature		**Date signed** DD/MM/YYYY	

12	**Plan 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** DD/MM/YYYY	

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