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Employee Change Form

PLEASE COMPLETE NEATLY, SIGN SECTIONS SEVEN (IF REQUIRED) AND ELEVEN, AND RETURN THE ORIGINAL TO LEWER CANADA. For more information please contact us by phone or email.

Section One – Information About You, to be Completed by Employee

Note: By providing your email address you are authorizing us to use this email address and other information for communication purposes with you.

Full Name	Date of Birth
	(Month / Day / Year)
Employer Name	**Your E-Mail Address**
Policy Number	**Certificate Number**

Section Two – Tell Us What You Want To Do

I want to provide information about:

☐ **Adding Dependents** (Complete Section 3 & Section 11)

☐ **Over Age Dependent** (Complete Section 4 & Section 11)

☐ **Name Change / Correction for Myself or Dependents** (Complete Section 5 & Section 11)

☐ **Date of Birth Correction for Myself or Dependents** (Complete Section 6 & Section 11)

☐ **Beneficiary / Contingent Beneficiary / Trustee** (Complete Section 7 & Section 11)

☐ **Irrevocable Beneficiary Authorization** (Complete Section 8 & Section 11)

☐ **Electronic Funds Transfer – Bank Information** (Complete Section 9 & Section 11)

☐ **Address / Contact Information** (Complete Section 10 & Section 11)

Section Three – Adding Dependents

	First Name	Last Name	Gender	Date of Birth	Dependent Status	Dependent of Whom
Spouse				Month / Day / Year	☐ Common Law ☐ Married	
Child (1)				Month / Day / Year	☐ Total Disability ☐ Student	☐ You ☐ Spouse ☐ Both
Child (2)				Month / Day / Year	☐ Total Disability ☐ Student	☐ You ☐ Spouse ☐ Both
Child (3)				Month / Day / Year	☐ Total Disability ☐ Student	☐ You ☐ Spouse ☐ Both
Child (4)				Month / Day / Year	☐ Total Disability ☐ Student	☐ You ☐ Spouse ☐ Both

*If you require more space, please use an additional change form and complete applicable sections.

Section Four – Over-Age Dependents

1. **Over Age Dependent-Student** – If you have dependent children who have reached the first age limit for coverage stipulated in the contract who are still attending school full time, please complete the confirmation of school attendance information below. Coverage for over-age dependents will terminate on August 31st of each year, therefore, the plan member must re-apply if the child re-enrolls in the following school year.

2. **Total Disability** – the dependent child has a total and permanent physical or mental handicap and is totally dependent on the plan member. Additional and ongoing information may be required.

First Name	Last Name	Date Enrolled as a Full Time Student
		Month / Day / Year to *Month / Day / Year*
Name and Address of Accredited School		

First Name	Last Name	Date Enrolled as a Full Time Student
		Month / Day / Year to *Month / Day / Year*
Name and Address of Accredited School		

*Coverage will cease August 31 of each calendar year. Updated post-secondary information will be required for continued coverage beginning September 1st the next year.

*Please request an additional drug card if required for your dependent.

Section Five – Name Change / Correction for Myself or Dependents

New / Corrected First Name	New / Corrected Last Name	Reason For Change
		☐ Marriage ☐ Correction ☐ Other
If Other, Please Specify:		

* Do you need to update coverage, beneficiary or bank information? Please complete Sections 7, 8 and 9 if required.

Section Six – Date of Birth Correction for Myself or Dependents

First Name	Last Name	Correct Date of Birth
		Month / Day / Year
		Month / Day / Year
		Month / Day / Year

Section Seven – Beneficiary Change

Any changes, amendments or overwrites to information you provide below will require your initials.

PRIMARY BENEFICIARY (note, this will replace any previous beneficiary assignment)

First Name	Last Name	Date of Birth	%	Revocable	Irrevocable	Relationship to employee
		Month / Day / Year		☐	☐	
		Month / Day / Year		☐	☐	
		Month / Day / Year		☐	☐	
		Total (must be equal to 100%)				

CONTINGENT BENEFICIARY (note, this will replace any previous beneficiary assignment)

First Name	Last Name	Date of Birth	%	Revocable	Irrevocable	Relationship to employee
		Month / Day / Year		☐	☐	
		Month / Day / Year		☐	☐	
		Month / Day / Year		☐	☐	
		Total (must be equal to 100%)				

If the beneficiary or contingent beneficiary is a minor (under the age of 18), please designate a trustee:	
Relationship of trustee to employee:	

Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary. In Quebec, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. The policy does not confer any rights to contingent beneficiaries prior to the death for the primary beneficiaries.

I hereby declare the above designation of my benefits.

Signature of Employee _____ Date _____

Section Eight – Irrevocable Beneficiary

COMPLETE ONLY IF YOU HAVE AN IRREVOCABLE BENEFICIARY AND ARE MAKING CHANGES TO YOUR IRREVOCABLE BENEFICIARY(IES)

Irrevocable Beneficiary means that all changes must be authorized by the irrevocable beneficiary.

First Name	Last Name

I hereby consent to any change of beneficiary under this contact. I hereby declare that I am of legal age.

Be sure to show the Irrevocable beneficiary's first and last name. The irrevocable beneficiary must complete the form in ink, sign and date the form.

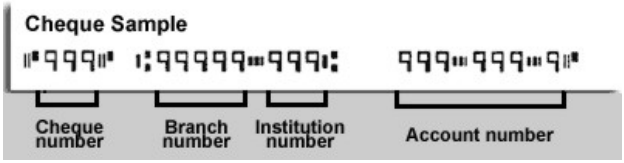
A witness must sign the form in ink. Also include the witness' name in printed form. The member cannot sign as the witness.

Signature of Irrevocable Beneficiary	Date
Signature of Witness	Date
Witness First Name(Please Print)	Witness Last Name (Please Print)

Section Nine – Electronic Fund Transfer – Bank Information

DIRECT DEPOSIT FOR REIMBURSEMENTS - <u>Mandatory</u> for electronic submission of claims

Please complete below or attach a void cheque for Direct Deposit of Reimbursements (Mandatory for electronic submission of claims, Mobile and Web Based Applications. You will receive an email summary of your Explanation of Benefits with each claim and have access to claims and coverage information through the Mobile and Web Based Applications).



Cheque Number	Branch Number	Institution Number	Account Number

Section Ten – Address / Contact Information

Note: By providing your email address you are authorizing us to use this email address and other information for communication purposes with you.

Street Address	Apartment/Unit #

City	Province	Postal Code

Home Phone	Alternate Phone

Email Address

EMERGENCY CONTACT INFORMATION

First Name	Last Name	Phone Number

Section Eleven – Declarations and Authorizations

I confirm that the information and answers that I have provided in this document are true and complete. I certify that I am an active full time employee working at least the minimum required hours per week at the above named company and I understand that if I do not meet these requirements I am not eligible for any insurance or benefit covered through this program.

I authorize Lewer Canada Ltd. to deposit all my claim reimbursements to the designated bank account.

I authorize any insurer, reinsurer, physician, health care provider or professional, pharmacy, hospital, clinic my group insurance administrator, administrator of a government or other fringe benefits program, organization or service provider within the scope of my group insurance plan that holds information pertaining to me or my dependents to exchange such records or information with Lewer Canada Ltd. for the purposes of determining eligibility to benefits and for plan administration or claims analysis purposes. This information may be of a medical or other nature.

In the event of death, I authorize any beneficiary, heir or executor to provide Lewer Canada Ltd or its reinsurers with all information or authorizations deemed necessary for claims adjudication purposes and for obtaining supporting documents. I authorize any coroner, police force or toxicologist that holds my personal information, including any accident and police investigations reports regarding a claims communication of my personal information (other than medical nature) to any private investigator and authorize this private investigator to communicate any information collected regarding me to Lewer Canada Ltd.

This authorization is valid for the purposes of this contract, its modification, its extension or its reinstatement. I acknowledge that any reproduction of this authorization shall be as valid as the original.

I authorize Lewer Canada to use my personal information in order to send me information on other products and services that might interest me. If not, please check the following: ☐ I do not authorize this use.

I hereby understand that coverage will be effective when approved by the insurers and give consent for underwriting, administration and claims adjudication and allows us to use personally identifiable claim information for predictive modeling and intervention at the individual level.

I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them for the purposes as stated above.

Signature of Employee _____ Date _____