

<b>For office use only</b>
Morneau Shepell Authorized Signature
Comments

- Sections **1** and **3 – 7** to be completed by Plan Sponsor/Employer in ink.
- Sections **2** and **8 – 13** to be completed by Plan Member/Employee in ink.
- Section **14** to be signed by Plan Member/Employee and Plan Administrator in ink.
- \*\* For sections **3 – 13**, please complete only the section that relates to your change.
- Return the ORIGINAL to the Plan Sponsor/Employer.
- Return a PHOTOCOPY to: (Mail) Morneau Shepell, 895 Don Mills Road, 4th Floor, Toronto ON M3C 1W3 or (Fax) 1-877-464-0109.

## 1 Plan Sponsor/Employer Information

Client name	Client/division code	Class	Insurance company name(s) A)
Policy/group contract numbers	Cost centre (if applicable)	Effective date of change D D / M M / Y Y Y Y	B)

## 2 Plan Member/Employee Information

Last name	First name	Middle initial	Marital status	S.I.N./Plan member ID #
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## 3 Employment Status Change

Current employment status <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="radio"/> Seasonal/contract <input type="radio"/> Terminated	Effective: D D / M M / Y Y Y Y	Hours worked/week
New employment status <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="radio"/> Seasonal/contract <input type="radio"/> Terminated	Effective: D D / M M / Y Y Y Y	Hours to be worked/week

## 4 Salary Change

Current annual salary	New annual salary
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## 5 Division Transfer

Current division	New division
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## 6 Class Change

Current class	New class
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## 7 Cost Centre Change

Current cost centre	New cost centre
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## 8 Name Change

<input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependant	Current last name	Current first name	Current middle initial
	New last name	New first name	New middle initial

## 9 Address Change

Current mailing address			New mailing address		
City	Province	Postal Code	City	Province	Postal Code

## 10 Coverage Change

Health <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	Dental <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	Effective: D D / M M / Y Y Y Y
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## 11 Birth Date Correction

<input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependant	Current birth date D D / M M / Y Y Y Y	
	New birth date D D / M M / Y Y Y Y	

## 12 Beneficiary Change

If you designate a beneficiary who is:  
 (a) under 18 years of age, or  
 (b) mentally incapacitated  
 you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

If you are a Quebec resident and you designate your spouse as a beneficiary, you are not permitted to change that beneficiary unless you:

- (a) indicate that your designation of beneficiary is revocable, by checking the box on this form, or
- (b) your spouse agrees, in writing, to be removed as your beneficiary.

Original beneficiary information will be kept by your Plan Sponsor/Employer.

### Name your beneficiary(ies)

Beneficiary's last name	Beneficiary's first name	
Relationship to Plan Member		Percent allocated %
Beneficiary's last name	Beneficiary's first name	
Relationship to Plan Member		Percent allocated %
Beneficiary's last name	Beneficiary's first name	
Relationship to Plan Member		Percent allocated %
		Total %

I appoint \_\_\_\_\_ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

#### For Quebec Residents Only

If you have designated your spouse as beneficiary, the designation will be irrevocable, unless you indicate that you wish it to be revocable below.

I wish to make my designation:  Revocable  Irrevocable

## 13 Add or Delete a Dependent

Add  Delete

Spouse's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender <input type="radio"/> M <input type="radio"/> F
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Add  Delete

Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender <input type="radio"/> M <input type="radio"/> F	Student <input type="radio"/> Yes <input type="radio"/> No
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Add  Delete

Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender <input type="radio"/> M <input type="radio"/> F	Student <input type="radio"/> Yes <input type="radio"/> No
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Reason:

## 14 Plan Member/Employee Declaration

I consent to the collection, use, and exchange of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, and/or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependent children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to share information as it relates to the plan.

I hereby apply for group benefits under my Plan Sponsor's/Employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor/Employer.

\_\_\_\_\_  
Plan Member/Employee signature

\_\_\_\_\_  
Plan Administrator signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Date signed