

RETIREE NOTICE OF CHANGE



Policy No. 160978
Ambulance/Hospital, Extended Health, Dental

Must submit within **60 days** of the Life Event

NAME: _____ ID #: _____ HOME TELEPHONE: _____

1. <input type="checkbox"/> CHANGE OF NAME										
Surname:					Given Name and Middle Initial(s):					
2. <input type="checkbox"/> CHANGE OF ADDRESS AND/OR HOME TELEPHONE										
Address:					City:					
Province:			Postal Code:			Home Telephone: ()				
3. <input type="checkbox"/> ADD SPOUSE										
Surname (if different from Employee Surname):			Given Name and Middle Initial(s):		Birth Date (month/day/year):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Undisclosed			
<input type="checkbox"/> Legally Married <input type="checkbox"/> Common Law		If common law, please provide commencement date of cohabitation (month/day/year):								
4. <input type="checkbox"/> DELETE SPOUSE										
Surname (if different from Employee Surname):			Given Name and Middle Initial(s):		Reason:		Effective Date (month/day/year):			
5. <input type="checkbox"/> ADD UNMARRIED DEPENDENT CHILDREN (Please use back of this page if additional space required.)										
Surname (if different from Employee Surname)	Given Name and Middle Initial(s)	Gender				Birth Date (month/day/year)	Full-time Student		Disabled prior age 22	
		Male	Female	Other	Undisclosed		Yes	No	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <input type="checkbox"/> DELETE DEPENDENT CHILDREN										
Surname (if different from Employee Surname):			Given Name and Middle Initial(s):		Reason:		Effective Date (month/day/year):			

7. CHANGE GROUP BENEFITS COVERAGE (You are only permitted to downgrade from your current Option.)

Benefits Coverage Section	Select only one	Retirees must enroll according to their true family status.		
		Single	Couple	Family
Terminate group benefits coverage	<input type="checkbox"/>			
Option 1: Ambulance/Hospital	<input type="checkbox"/>	<input type="checkbox"/> \$27.10	<input type="checkbox"/> \$52.70	<input type="checkbox"/> \$54.98
Option 2: Ambulance/Hospital & Extended Health	<input type="checkbox"/>	<input type="checkbox"/> \$87.03	<input type="checkbox"/> \$158.09	<input type="checkbox"/> \$159.68
Option 3: Ambulance/Hospital & Extended Health & Basic Dental	<input type="checkbox"/>	<input type="checkbox"/> \$128.20	<input type="checkbox"/> \$240.18	<input type="checkbox"/> \$254.37
Option 4: Enhanced Coverage	<input type="checkbox"/>	<input type="checkbox"/> \$215.31	<input type="checkbox"/> \$404.10	<input type="checkbox"/> \$431.70

Retirees may reduce coverage (i.e. switch to a lower option) at any time, but will not be permitted to rejoin after opting out or to upgrade their option.

8. CHANGE BANKING INFORMATION

Funds can only be withdrawn from either a chequing or savings account. Please attach a copy of a void cheque.

Chequing Account Savings Account

Branch Transit #: _____ Institution #: _____ Bank Account #: _____

Bank Name: _____

Bank Address: _____

9. OTHER CHANGES

Specify:

10. AUTHORIZATION

I authorize HUB International:

- To automatically debit my bank account for the monthly premium under the Retiree Group Benefits Plan and remit to Canada Life;
- To exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

Premium rates are reviewed annually and are subject to change. You will be notified in advance of any changes. I understand that if there are insufficient funds in the account to cover the monthly withdrawal, benefits will cease at the end of the month and a fee may be assessed to reinstate and/or may be required to submit medical evidence of good health.

I agree that a photocopy or electronic copy of this application is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Retiree Signature: _____ **Date (month/day/year):** _____

Please submit completed form to:
HUB International
Attn: RRC Polytech Retiree Benefits
5th flr – 1661 Portage Ave., Winnipeg, MB, R3J 3T7
Telephone: 1-844-984-9456
E-mail: RRCretiree@hubinternational.com

OFFICE USE ONLY:

This communication is available in alternative formats upon request. To request an alternative format, please contact HUB International at RRCretiree@hubinternational.com or toll-free at 1-844-984-9456.

Changed on GroupNet by:	Date Entered (month/day/year):
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