Equitable Life of Canada®

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GROUP PLAN MEMBER CHANGE FORM

Name of Group Policyholder:	Group Policy Number:	Group Division Number:
Name of Plan Member (First, Middle, Last):		Certificate Number:

Please check off appropriate box(es): ***(See Instructions on the back of this form)***

❑ **Section 1 - Notification of Marriage or Partnership Relationship** (For changes to your group benefits requirements, Section 3 below must be completed.)

❑ I was married on (month)_____ / (day)_____ / (year)_____ , OR ❑ We began living together as partners on (mm/dd/yyyy):_____

Name of Spouse/Partner (First, Middle, Last):	Date of Birth (mm/dd/yyyy):

❑ **Section 2 - Notification of Change of Name**

On (month)_____ / (day)_____ / (year)_____ , my name changed:

From (First, Middle, Last):	To (First, Middle, Last):
Reason for name change (e.g. marriage, divorce):	

❑ **Section 3 - Application for Change in Coverage** (Please see reverse for definitions of eligible dependents.)

❑ Add **or** ❑ Remove	Name of Dependent (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Relationship to Plan Member:
	Indicate Reason for change:		Effective Date (mm/dd/yyyy):
❑ Add **or** ❑ Remove	Name of Dependent (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Relationship to Plan Member:
	Indicate Reason for change:		Effective Date (mm/dd/yyyy):

If more than 2 dependents, provide information on reverse side

I wish to apply for:

- **Health** → ❑ for myself only* ❑ for myself and family ❑ Coordination of Benefits* **or** ❑ **forfeit** (opt out of) coverage*
- **Dental** → ❑ for myself only* ❑ for myself and family ❑ Coordination of Benefits* **or** ❑ **forfeit** (opt out of) coverage*

You may forfeit Health and/or Dental Benefits ONLY if covered for similar benefits under your spouse's/partner's plan.

*Does your spouse/partner have coverage elsewhere? ❑ Yes ❑ No → If "yes", you must complete the following information:

My spouse and children have coverage through:	*Name of Insurance Carrier:

I understand that I can join the Health/Dental plan with Equitable Life® if I apply within 31 days of the termination of my spouse's/partner's coverage with his/her Employer. If I apply more than 31 days after the termination of my spouse's/partner's coverage, evidence of insurability will be required, and Dental coverage will be restricted. If I and/or my dependents have no current Group coverage, I understand I/we can apply in the future only with satisfactory evidence of insurability, and coverage may be restricted or denied.

❑ **Section 4 - Declaration Appointing Beneficiary**

NOTE: If no beneficiary is appointed, the proceeds shall be paid to the deceased's estate. If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. I revoke the previously appointed Primary and Contingent beneficiary(ies). I understand that policy proceeds will now be payable to:

Name(s) of Primary Beneficiary(ies): (First, Middle, Last)	Relationship(s) to Plan Member:

if living at my death, otherwise to:

Name(s) of Contingent Beneficiary(ies): (First, Middle, Last)	Relationship(s) to Plan Member:

if living at my death, otherwise to my estate. If the beneficiary is under 18 years of age at the time of my death, proceeds of the said policy shall be payable to the following, in trust for the beneficiary.

Name of Trustee	I reserve the right to change the appointed beneficiaries.

NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.
I elect to make my spouse beneficiary designation: ❑ Revocable

Certification and Authorization Please sign and date this form to authorize the changes.

I hereby certify all the information provided on this form is complete, current and accurate.
The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and/or Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits thereunder, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by, Equitable Life, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians and dentists, and any other person or party whom I authorize.
If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I hereby certify that all of the information provided above is current and accurate. I authorize the use of my S.I.N. for identification purposes and designate the beneficiary as stated above.	
Signature of Insured/Plan Member:	Date (mm/dd/yyyy):

GROUP PLAN MEMBER CHANGE FORM INSTRUCTIONS

IMPORTANT: **PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY.**
Incorrect or incomplete information will result in denial or improper payment of your claims.

For the purposes of this Group Insurance Policy, "Spouse" means:
a) the legally married husband or wife of the Plan Member, or
b) a person of the same or opposite sex who resides with the Plan Member in a conjugal relationship and is publicly represented as the partner of the Plan Member.

"Dependent" means EITHER a spouse as defined above, AND/OR your natural child, adopted child, stepchild or child of your spouse, under the age of 21, who normally resides with you.

Section 1: Notification of Marriage or Partnership Relationship

- Check the appropriate box: Marriage or Partner Relationship*****
- Indicate the exact date of marriage, or the date you began living as partners in a conjugal relationship and publicly represented him/her as your partner. For Partner Relationships: Please note you cannot provide coverage to your legal spouse (if applicable) and your partner concurrently.
- Indicate Spouse's/Partner's Full Name and Date of Birth.
- If you now require a change to your Group benefits, be sure to complete Section 3, Application for Change in Coverage.

Section 2: Notification of Change of Name

- Indicate previous first and last name, and current first and last name.
- Indicate the reason for change (eg divorce, marriage), and your new marital status, if applicable.

Note: If the reason for this name change also causes a change to your requirements for group benefits, (e.g. adding or deleting dependents), be sure to advise Equitable Life. (Refer to section 3 below.)

Section 3: Application for Change in Coverage / *Forfeiture / *Coordination of Health and/or Dental Benefits

- Indicate the names and dates of birth of all dependents requiring coverage and their relationship to the employee (example: Jane Smith-Spouse, Susan Smith- child).
- Indicate the reason and the effective date for the change (example: Marriage, Divorce, New Child, Employment Change, Child no longer dependent).

If you are covered for Health and/or Dental Benefits through your spouse's employer, the following may apply:
a) *Forfeiture of Health and/or Dental Benefits – You may opt out of Health and/or Dental Benefits on this plan by completing the appropriate Section(s) on the reverse side.
NOTE: This section is also to be completed if you have a dependent (such as a spouse, partner or child) who is covered under another plan, but you require Health and/or Dental coverage for YOURSELF ONLY.

b) *Coordination of Health and/or Dental Benefits – Coordination of Benefits allows you to submit claims under one plan and submit any remaining unpaid amount to the other insurance carrier.

NOTE: CANADIAN LIFE & HEALTH ASSOCIATION REGULATIONS STIPULATE:

- A spouse/partner must submit claims to his/her employer's plan FIRST.
- Claims for insured children must first be submitted to the plan insuring the spouse/partner whose date of birth is the earliest in the calendar year. If both spouses/partners were born in the same MONTH, the earlier DAY would be the rule.

❑ Add **or** ❑ Remove	Name of Dependent (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Relationship to Plan Member:
	Indicate Reason for change:		Effective Date (mm/dd/yyyy):
❑ Add **or** ❑ Remove	Name of Dependent (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Relationship to Plan Member:
	Indicate Reason for change:		Effective Date (mm/dd/yyyy):

Section 4: Beneficiary Designations

- Indicate the full name and relationship of the Beneficiary(ies) to you in the space provided.
- You have the right to change the Beneficiary at any time; however, where Quebec law applies, the beneficiary designation for your spouse must be designated as revocable to reserve this right.
- If, in the event of a Life claim, the Primary Beneficiary is also deceased, policy proceeds will be payable to the appointed Contingent Beneficiary, otherwise to the estate.
- If more than one Beneficiary is appointed, proceeds will be payable in equal shares, unless you indicate otherwise.
- If the appointed Beneficiary is under 18 years of age, a Trustee of legal age should be appointed. If a Trustee is not appointed, proceeds will be paid to the Estate of the deceased. The full name of the Trustee is required. The Trustee for a Contingent Beneficiary cannot be the primary beneficiary.
  NOTE: You cannot appoint yourself as trustee or as beneficiary.

Your Signature and the Date are required to process any changes.