

The appropriate section(s) below should only be completed as changes to the reverse side are required. **Please return this form to your District Benefits Administrator once completed.** The benefits administrator should file this form for future reference.

Group Insurance Changes TEACHERS

Part 1: Employee Identification

Employee's Last Name	First Name	Initial	ID Number	Provincial Health Plan Number (Care Card)
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Part 2: Change in Family Status

Change of coverage requested due to the following "event": <input type="radio"/> Marriage <input type="radio"/> Cohabitation <input type="radio"/> Divorce <input type="radio"/> Separation <input type="radio"/> Death <input type="radio"/> Birth <input type="radio"/> Adoption <input type="radio"/> Other (specify):	Date of Event (M/D/Y)
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Revised Extended Health Coverage <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)	Revised Dental Coverage <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)
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Add	Delete	No.	Dependent's First Name	Initial	Last Name (if different from Employee)	Birthdate (M/D/Y)	Relationship	Gender M – Male F – Female X – Another Gender U – Prefer Not to Disclose	Provide name of school and student number if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								
<input type="radio"/>	<input type="radio"/>								

Part 3: Change to Spousal or Other Coverage

Change of <input type="radio"/> Dental <input type="radio"/> Extended Health coverage requested due to: <input type="radio"/> Spouse's plan terminated – enroll on BCPSEA plan (ensure Group Insurance Application is up to date or note additions on this form) <input type="radio"/> Transferring to Spouse's plan - terminate from BCPSEA plan by completing Waiver of Coverage Form. Spouse's policy number: _____	Date of Change (M/D/Y)
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Revised Extended Health Coverage: <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)	Revised Dental Coverage: <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family <input type="radio"/> Waived (attach Waiver of Coverage form)
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Part 4: Change of Life Insurance Policy

Class 1 Employees With No Dependents: <input type="radio"/> Basic \$9,000, OR <input type="radio"/> 2½ times Category 5 minimum salary	Class 2 Employees With Dependents, married Employees or Court Order Maintenance. <input type="radio"/> 2½ times Category 5 minimum salary, OR <input type="radio"/> Optional multiple of salary based on age
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Part 5: Change of Beneficiary Designation

New Beneficiary - Last Name	First Name	Initial	Share of Proceeds	Relationship	Name of Trustee for Beneficiaries Under 18
			%		
			%		
			%		

To which benefit(s) does this change apply? All applicable benefits, or: Basic Life Optional Life Basic AD&D Optional AD&D

Part 6: Change of Name

Previous Last Name	First Name	Initial	Date of Change (M/D/Y)
New Last Name	First Name	Initial	<input type="radio"/> Employee <input type="radio"/> Dependent

Part 7: Change of Employee's Address				
Apt / Unit Number	Street Address			Date of Change (M/D/Y)
City		Province	Postal Code	Phone Number ()

I hereby confirm the above information is complete, true and correct. I understand that if this application is completed more than 31 days after any change in family status, satisfactory evidence of insurability will be required to add dependents to this plan. I reserve the right to change my beneficiary at any time.

Employee Signature _____

Date Signed (M / D / Y) _____