CANADIAN BENEFIT PROVIDERS

PLAN MEMBER CHANGE FORM

PART 1 | YOUR INFORMATION

PLAN SPONSOR/GROUP NAME					
PLAN MEMBER NAME (Last Name, First Name)				DATE OF BIRTH (mm/dd/yyyy)	
GROUP #				MEMBER ID #	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

PART 2 | CHANGE OF NAME / ADDRESS

FROM (Last Name, First Name)					
TO (Last Name, First Name)					
NEW MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	

PART 3 | CHANGE IN DEPENDANTS

ADD/ CHANGE/ DELETE	DEPENDANT NAME (Last Name, First Name)	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (mm/dd/yyyy)	SEX (M/F)	FULL-TIME STUDENT* (Y/N)	DISABLED DEPENDANT* (Y/N)

* Complete related form: Over-Age Dependant Form for a new Full-Time Student; the Application for Disabled Dependant Coverage to register a disabled dependant.

PART 4 | COORDINATION OF BENEFITS

What Group Benefits coverage from your spouse/common-law spouse would you like to add, change or delete?

ADD/CHANGE/DELETE	HEALTH	DENTAL	VISION
	SINGLE ☐ FAMILY ☐	SINGLE ☐ FAMILY ☐	SINGLE ☐ FAMILY ☐

NAME OF SPOUSE'S INSURER	POLICY NUMBER

Please note: Coverage may only be waived if you and/or your dependants **are** covered by a spousal plan.

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PART 5 | APPLICATION FOR COVERAGE

If provided by the policy, I elect the following change of coverage:

	Single	Family	Waived
Health	☐	☐	☐
Dental	☐	☐	☐

Health and Dental coverage may only be removed if you have DUPLICATE group benefits through your spouse's employer. If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you may be required to provide acceptable proof of your insurability to be covered. If you are approved, dental benefits, if applicable, may be restricted. Please see your plan administrator for details.

PART 6 | AUTHORIZATION & DECLARATIONS

Whereas the "Company" refers Canadian Benefit Providers Inc., **I certify** that the information in this form is true and complete to the best of my knowledge. **I acknowledge** and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** the collection, use, maintenance and disclosure of personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with my Plan Advisor, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Information provided to or collected in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to: Plan Advisor employees, representatives, reinsurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law.

I authorize all future claims payments to be sent via electronic funds transfer to the bank account listed here. **I agree** that I will access my Explanation of Benefits via the secured employee web portal and that I will maintain a current email address to receive notification of payments as they occur. **I recognize** that it is my responsibility to ensure that my file is kept up-to-date with my preferred bank account information and personal information. **I agree** that the Company will not be responsible for any payments that are lost or misdirected due to incorrect banking information. **I authorize** the deduction from my pay of any contributions I must make towards the cost of these benefits. **I agree** that a photocopy or electronic version of this authorization is valid.

EFFECTIVE DATE OF CHANGE (mm/dd/yyyy)	

PLAN MEMBER SIGNATURE	DATE SIGNED (mm/dd/yyyy)
PLAN ADMINISTRATOR SIGNATURE	**DATE SIGNED (mm/dd/yyyy)**

Send completed and original forms to your Plan Administrator; retain a copy for your files.

Plan administrators, forward this completed form by email, fax or mail to:
Email | admin@cbproviders.ca Fax | 1.844.944.9168
Mail | Canadian Benefit Providers 301-8925 51 AVE NW EDMONTON AB T6E 5J3 Canada

Questions? Call us at 780.944.9166 or toll free at 855.944.9166