RBC Insurance

GROUP BENEFIT PLAN MEMBER CHANGE FORM

Sections 1, 2 & 6 are to be completed by the Plan Administrator and Sections 3 through 6 are to be completed by the plan member, for applicable changes. The Plan Administrator should keep the original of the completed form for their records and send a copy to RBC Life Insurance Company.

1. GENERAL INFORMATION

This section is mandatory and must be completed by an authorized Plan Administrator.

Effective Date of Change: (yyyy/mm/dd)			RBCI ID Card Required: ☐
Name of Employer		RBCI Policy No.	Billing Division No.
Plan Member Last Name	First Name	Initial	Plan Member ID No.

2. PLAN ADMINISTRATOR SECTION *Please check off appropriate box(es)*

An Authorized Plan Administrator must confirm eligibility prior to completing this section based on the required hours of your benefit plan.

☐ Salary, Occupation, Class or Billing Division

Occupation		Class	Billing Division
Earnings: $	☐ Hr. ☐ Wk. ☐ Mth. ☐ Yr.	Hrs per week:	

☐ Termination

I confirm that this plan member is no longer eligible for coverage because _____

(Reasons for Termination: Termination of Employment, Deceased, Retirement, Layoff, Leave of Absence)

3. PLAN MEMBER SECTION *Please check off appropriate box*

This Section must be completed if you are changing your name, updating your mailing address or have a date of birth correction.

☐ Name, Address or Date of Birth Correction

Plan Member's New Name: (last, first)		Date of Birth: (yyyy/mm/dd)
Home Mailing Address:		
City	Province	Postal Code

4. CHANGE IN DEPENDENT STATUS SECTION *Please check off appropriate box(es)*

This Section must be completed if you are adding or deleting a dependent, or updating dependent information.

Common-law spouse means that you lived with this person as your spouse or partner for a continuous period of at least 12 months.

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage.

If you do not apply within 31 days, you and your dependents may be required to provide proof of insurability and coverage may be restricted or denied.

Change My Benefit Status to: ☐ Single ☐ Couple ☐ Family

Reason for Change: ☐ Marriage ☐ Common-law ☐ Loss of Spousal Coverage ☐ Divorce ☐ Birth/Adoption of Child

Date of Marriage/Common-law: (yyyy/mm/dd) _____

Due to this change in dependent status, I would like to: ☐ Add Dependent Life ☐ Remove Dependent Life

☐ Refusal of Health and/or Dental Coverage or Co-ordination of Benefits

If you and/or your dependents are presently covered for Health and/or Dental Coverage under your spouse's Group Benefit Contract you may refuse to be covered for such benefits under this contract or Co-ordinate Benefits.

_____ Name of Your Spouse's Group Insurer

_____ Start Date of Coverage (yyyy/mm/dd)

*I understand the plan of Group Benefits offered to me, but **I wish** to:*

Health Coverage:	☐ Decline coverage for myself and my dependents	☐ Decline coverage for my dependents	☐ Co-ordinate benefits
Dental Coverage:	☐ Decline coverage for myself and my dependents	☐ Decline coverage for my dependents	☐ Co-ordinate benefits

To add these benefits, you must apply for coverage within 31 days, of loss of spousal coverage.

If you are applying after 31 days, you must complete an Evidence of Insurability Form

☐ Addition of Health and Dental Coverage

You may apply to be enrolled for Health and/or Dental coverage if your spouse has lost coverage through his/her employer.

Effective Date of Loss of Coverage Through Spouse's Group Contract: (yyyy/mm/dd) _____

I am no longer covered under my spouse's Group Benefit Contract and I hereby ***request to add:***

Health Coverage: ☐ Coverage for Myself and My Dependents ☐ Coverage for Myself

Dental Coverage: ☐ Coverage for Myself and My Dependents ☐ Coverage for Myself

If there are more than four dependents, please attach a separate list.

Information on Your Dependent(s) Specify: ☐ Add ☐ Change ☐ Remove

Dep.	Last Name	First Name	Initial	Date of Birth (yyyy/mm/dd)	Gender (M/F)	Full-Time Student	Overage Disabled Dependent
Spouse							
1st Child						☐	☐
2nd Child						☐	☐
3rd Child						☐	☐
4th Child						☐	☐

5. OPTIONAL LIFE SECTION

This section should only be completed by an employee if Optional Life is part of your Group Benefit Contract.

☐ Smoker/Non-Smoker Status Rate Change Request

I have ***not*** used any narcotic, tobacco product, marijuana or hashish, smoking cessation products, tobacco substitute such as betel nuts, betel leaves, supari, paan or gutka within the last twelve (12) months: ☐

I have ***begun to*** use a narcotic, tobacco product, marijuana or hashish, smoking cessation products, tobacco substitute such as betel nuts, betel leaves, supari, paan or gutka within the last twelve (12) months: ☐

☐ Decreasing Amount or Discontinuing Optional Life Coverage

Remove Coverage for: ☐ Self ☐ Spouse ☐ Children

Decrease Amount to: ☐ Self _____ ☐ Spouse _____ ☐ Children _____

6. DECLARATIONS, AUTHORIZATIONS AND SIGNATURES

This section must be signed and dated by both the Plan Member and the Plan Administrator.

I authorize RBC Life Insurance Company to carry out the above-mentioned transaction(s) in keeping with the rights, terms and conditions of the Policy/Contract.

A photocopy or electronic copy of this change form and authorization will be as valid as the original.

Plan Member Signature: _____ Date: (yyyy/mm/dd) _____

Plan Administrator Signature: _____ Date: (yyyy/mm/dd) _____