PUBLIC EDUCATION BENEFITS TRUST

Benefits Change Form

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

Part 1: Employee Identification

Employee's Last Name	First Name	Initial	District #	Provincial Health Plan Number (Care Card)

Part 2: Change in Family Status

Change of coverage requested due to the following "event":

Date of Event (mm/dd/yyyy)

❑ Marriage ❑ Cohabitation ❑ Divorce ❑ Separation ❑ Death ❑ Birth ❑ Adoption

❑ Other (specify):

Revised Extended Health Coverage	Revised Dental Coverage
❑ Single ❑ Couple ❑ Family ❑ Waived (attach Waiver of Coverage form)	❑ Single ❑ Couple ❑ Family ❑ Waived (attach Waiver of Coverage form)

Add	Delete	No.	Dependent's First Name	Initial	Last Name (if different from Employee)	Birthdate (mm/dd/yyyy	Relationship	Gender (M/F)	Provide name of school below if child is over 21 and studying full time. If child is handicapped, state nature of disability and attach full details.
❑	❑								
❑	❑								
❑	❑								
❑	❑								
❑	❑								

Part 3: Change to Spousal or Other Coverage

Change of ❑ Dental ❑ Extended Health coverage requested due to:

Date of Change (mm/dd/yyyy)

❑ Spouse's plan terminated – enrol on PEBT plan (ensure Group Insurance Application is up to date or note additions on this form)

❑ Transferring to Spouse's plan - terminate from PEBT plan by completing Waiver of Coverage Form

Revised Extended Health Coverage	Revised Dental Coverage
❑ Single ❑ Couple ❑ Family ❑ Waived (attach Waiver of Coverage form)	❑ Single ❑ Couple ❑ Family ❑ Waived (attach Waiver of Coverage form)

Part 4: 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 5: Change of Name

Previous Last Name	First Name	Initial	Date of Change (mm/dd/yyyy)
New Last Name	**First Name**	**Initial**	❑ Employee ❑ Dependent

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 (mm/dd/yyyy) _____