

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

Benefits Change Form

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	l Health Plan Number (Care Card)	
Part 2: Char	ge in	Family Status									
Change of coverage requested due to the following "event":										Date of Event (mm/dd/yyyy)	
☐ Marriage ☐	Cohabita	tion Divorce Separation	on Death Birth A	doption							
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 (i from Employ		Birthdate (mm/dd/y	ууу	Relationship	Gender (M/F)	21 and st	name of school below if child is or udying full time. If child is sped, state nature of disability and Il details.	
Part 3: Char	ge to	Spousal or Other Cov	erage								
Change of Dental Extended Health coverage requested due to: Date of Change of Dental									Date of Change (mm/dd/yyyy		
Spouse's plan	erminate	ed – enrol on PEBT plan (ensure	e Group Insurance Application	n is up to date	or note add	itions on th	nis form)				
		s plan - terminate from PEBT p		•			,				
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)						
		Beneficiary Designation					·				
New Beneficiary -			First Name	rst Name Initial			Share of Proceeds Relationship		Name of Trustee for Beneficiaries Under		
						%					
						%					
To which benefit(s) does th	is change apply? All appli	cable benefits, or: Basic	Life 🖵 Opt	ional Life	Basic A	D&D 🗖 Optional	AD&D			
Part 5: Char	ge of	Name									
Previous Last Name				First Name			Initial			Date of Change (mm/dd/yyyy)	
New Last Name	New Last Name				First Name			Initial		Employee Dependent	
change in fam beneficiary at	ily sta any tii	tus, satisfactory eviden me.			ed to add	depend	lents to this pla	n. I rese		than 31 days after any ght to change my	
mnlovee Sig	nature		Date Signed (mm/dd/yyyy)								