



Blevins Administrative Services Inc.

30 Quarry Ridge Road, Barrie Ontario, L4M 7G1

Benefit Change Form

Purpose of Employee Change Form is to provide information regarding status changes that affect Group Benefits

Name of Policyholder		Policy Number	Certificate/Employee ID Number
Employee's Name Last Name _____ First Name _____		Social Insurance Number _____	
Employee's Address (if changed)			

1. Status/Coverage Change

Requesting Single/Family Health Coverage Reason: Marriage/Common Law
 Requesting Single/Family Dental Coverage Birth/Adoption of child
 Adding Dependents to Coverage Loss of Spousal Coverage

Name of Eligible Dependents Last Name, First Name	Gender M / F	Relationship to Insured	Date of Birth mm/dd/yyyy	Dependent Status S= F/T Student X=Disabled	Other Existing Coverage Health Dental Yes/No Yes/No		Date Effective* mm/dd/yyyy
Spouse							
Dependent							
Dependent							
Dependent							

*Include date dependent became eligible i.e. date of marriage, date spousal coverage cancelled

The following declaration must be completed for common-law relationship: I, the undersigned, hereby declare that I have been co-habiting with _____ in a common-law relationship since _____. I hereby apply for dependent benefits for this person as well as his/her natural children (if applicable). I realize that coverage for a previous spouse, if any, will be cancelled. I hereby declare that the statements I have made above are full, complete and true.

Signature Of Employee Date

2. Termination of Health and/or Dental Benefits Only

Please cancel health benefits because I have spousal coverage Effective Date of Spousal Coverage _____
 Please cancel dental benefits because I have spousal coverage mmm/dd/yyyy

3. Termination of Dependent Coverage

I no longer require family coverage and request to have all my dependents removed. Please change my coverage to single effective; _____
 Effective Date (mmm/dd/yy)

I wish to continue family coverage however request termination of the following ineligible dependents;

Name of Dependent	Reason for Change	Date Termination mmm/dd/yyyy

4. Beneficiary Change

Unless otherwise designated, the beneficiary appointment is 'Revocable'. If no beneficiary is designated, the beneficiary will be the estate of the deceased. Province of Quebec Residents, note, the appointment of a spouse as beneficiary is considered 'irrevocable' unless the word 'revocable' is actually written after the spouse's name.

Last Name and Full First Name	Percentage	Relationship

For employees with minor beneficiaries: I appoint (full name) _____, on _____, 20____ as Trustee to receive any amount payable to a minor beneficiary under this policy.

Signature Of Employee Date

5. Termination of Coverage

Termination of Employment State reason if other than termination; _____ Date Termination mmm/dd/yyyy
 Other

6. Employee Data Change

Salary Change: Annual Bi-weekly Hourly Earnings _____ Effective Date _____
 Name Change: New Last Name _____ Effective Date _____
 mmm/dd/yyyy

7. Class/Division Changes

Class Old Class _____ New Class _____ Effective Date _____
 Division Old Division _____ New Division _____ mmm/dd/yyyy

Signature of Employee and/or Plan Sponsor

Date