

Insurance

GROUP BENEFIT PLAN MEMBER CHANGE FORM

Use this form to help you capture changes for your plan members. 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 and then sign into <u>Online Administration</u> to make application changes. For assistance on making the applicable changes refer to 'How to' feature from your home screen within <u>Online Administration</u>.

1. GENERAL INFORMATION										
This section is mandatory and must be completed by an authorized Plan Administrator.	Effective Date of Change: (yyyy/mm/dd)									
	Name of Employer			RBCI Policy No. Billing Division						
	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	Salary, Occupation, Class or Billing Division									
confirm eligibility prior to completing this section based on the required hours of your benefit plan.	Occupation		Class Billing Division							
	Earnings: \$] 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	Name, Address or Date of Birth Correction									
changing your name, updating your mailing address or have a 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 STAT	US SECTION Please check off a	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.	Change My Benefit Status to:	Single Couple F	amily	Single	Parent					
	Reason for Change: Marriage Common-law Loss of Spousa 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									
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	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.									
and your dependents may be required to provide proof of insurability and coverage										
may be restricted or denied.	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 Decline coverage for Co-ordinate benefits and my dependents my dependents my dependents									
	Dental Coverage: Decline con and my de	verage for myself Decline pendents my dependents			o-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)										
If there are more than four dependents, please attach a separate list.	Information Dep.	on Your Dependent(s)	Specify: First Name	Add Initial	Change Date of Birth (yyyy/mm/dd)	Gender (M/F)	lime	e 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 <i>not</i> used any narcotic, tobacco product, marijuana or hashish, smoking cessation products, tobacci substitute such as betel nuts, betel leaves, supari, paan or gutka within the last twelve (12) months: I have <i>begun to</i> use a narcotic, tobacco product, marijuana or hashish, smoking cessation products, tobacci substitute such as betel nuts, betel leaves, supari, paan or gutka within the last twelve (12) months: 										
	Depressing Amount or Discontinuing Ontional Life Courses										
	Decreasing Amount or Discontinuing Optional Life Coverage Remove Self Decrease Amount for: Spouse to: Spouse coverage coverage										
					Childrer	1					
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 rights, terms and conditions of the Policy/Contract. Administrator. I authorize RBC Life Insurance Company to carry out the above-mentioned transaction(s) in rights, terms and conditions of the Policy/Contract. I authorize RBC Life Insurance Company to carry out the above-mentioned transaction(s) in rights, terms and conditions of the Policy/Contract. Administrator.											
	Plan Member Signature:				Date: (yyyy/ı	Date: (yyyy/mm/dd)					
	Plan Admir	nistrator Signature:			Date: (yyyy/r	mm/dd)					

Please retain this form for your records.

RBC Life Insurance Company, PO Box, 1600, 8677 Anchor Drive, Windsor, ON N9A 0B3, 1-855-264-2174, www.rbcinsurance.com