Equitable Life of Canada®

Head Office
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
TF 1.800.265.4556 **Fax** 519.883.7403

GROUP PLAN MEMBER CHANGE FORM

Name of Group Policyholder:	Group Policy Number:
Name of Plan Member (First, Middle, Last):	Certificate Number:

Please check off appropriate box(es):

Section 1 - Notification of Marriage or Partnership Relationship

(For changes to your group benefits requirements, Section 3 below must be completed.)

❑ I was married on (mm/dd/yyyy)_____, OR ❑ We began living together as partners on (mm/dd/yyyy) _____
I must apply within 31 days of marriage/common-law/partner relationship. If I apply more than 31 days after the date above, I understand that my spouse/partner will be required to provide evidence of insurability and coverage may be restricted or denied.

Section 2 - Notification of Change of Name

On (month)_____ / (day)_____ / (year)_____ , my name changed:

From (First, Middle, Last):	To (First, Middle, Last):
Reason for name change (e.g. marriage, divorce):	

Section 3 - Application for Change in Coverage (Please see reverse for definitions of eligible dependents.)

❑ Add **or** ❑ Remove	Name of Dependent (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Relationship to Plan Member:	
	Indicate Reason for change:		Effective Date (mm/dd/yyyy):	❑ male ❑ female
❑ Add **or** ❑ Remove	Name of Dependent (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Relationship to Plan Member:	
	Indicate Reason for change:		Effective Date (mm/dd/yyyy):	❑ male ❑ female

I wish to apply for: (Please check appropriate boxes)

❑ **Health** ❑ **Dental** – for myself only, as I have no eligible dependents (Single coverage)
*❑ **Health** ❑ **Dental** – for myself only, as my spouse/partner and/or children have coverage as noted below
❑ **Health** ❑ **Dental** – for myself and my family (Family coverage)
*❑ **Health** ❑ **Dental** – for myself and my family; and my spouse/partner and/or children also have coverage as noted (Coordination of Benefits)
I do not need ❑ **Health** ❑ **Dental** – as I am covered through my spouse's/Partner's plan as noted below (Forfeiture of coverage)

*Does your Spouse/Dependent have coverage elsewhere? ❑ Yes ❑ No If "Yes", you must complete the following information:
Spouse/Dependents have coverage through: *Name of Insurance Carrier: _____

❑ Remove Coordination of Benefits:
My spouse/partner no longer has coverage for ❑ Health ❑ Dental benefits effective _____(mm/dd/yyyy)

❑ Add Coordination of Benefits:
**Effective _____(mm/dd/yyyy) my spouse/partner obtained coverage for ❑ Health ❑ Dental. Please indicate Name of Insurance Carrier in space provided above.
**This request must be received at Equitable Life® within 31 days of the effective date of spouse's/partner's coverage.

I understand that I can join the Health/Dental plan with Equitable Life if I apply within 31 days of the termination of my spouse's/partner's coverage with his/her Employer. If I apply more than 31 days after the termination of my spouse's/partner's coverage, evidence of insurability will be required, and Dental coverage will be restricted. If I and/or my dependents have no current Group coverage, I understand I/we can apply in the future only with satisfactory evidence of insurability, and coverage may be restricted or denied.

If HCSA (Health Care Spending Account) amount needs to be adjusted as a result of changes above, please indicate new amount: _____

Group Plan Administrator Authorization

All changes listed above need to be authorized by your Group Plan Administrator; once you have completed this form please forward to your Group Plan Administrator's attention for authorization.

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

See pages 2 and 3 for Sections 4 (Declaration Appointing Beneficiary), 5 (Change of Address) and 6 (Change of Banking Information for Direct Deposit of claims).

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Section 4 - Declaration Appointing Beneficiary

NOTE: If no beneficiary is appointed, the proceeds shall be paid as required by provincial law. If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. I revoke the previously appointed Primary and Contingent beneficiary(ies). I designate that policy proceeds be payable to:

Name(s) of Primary Beneficiary: (First, Middle, Last) _____

Relationship to Plan Member: _____ %of share _____

Name(s) of Primary Beneficiary: (First, Middle, Last) _____

Relationship to Plan Member: _____ %of share _____

If the above Primary Beneficiary(ies) pre-deceases me, otherwise to:

Name(s) of Contingent Beneficiary: (First, Middle, Last) _____

Relationship to Plan Member: _____ %of share _____

Name(s) of Contingent Beneficiary: (First, Middle, Last) _____

Relationship to Plan Member: _____ %of share _____

If both the Primary Beneficiary(ies) and Contingent Beneficiary(ies) are deceased, the proceeds will be paid as required by provincial law.
NOTE: If there are additional Primary and/or Contingent Beneficiaries, please sign, date and attach a note with the beneficiary information to this form.

If the beneficiary is under the age of majority at the time of my death, proceeds of the said policy shall be payable to the following:

_____ _____
Name of Trustee Relationship to Plan Member

Note: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary. I elect to make my spouse (married or civil union) designation: ❑ Revocable

Section 5 - Change of Address / Email address

New mailing address: Street _____ City _____

Province _____ Postal Code _____ Effective Date _____
(mm/dd/yyyy)

New email address: _____ Effective Date _____
(mm/dd/yyyy)

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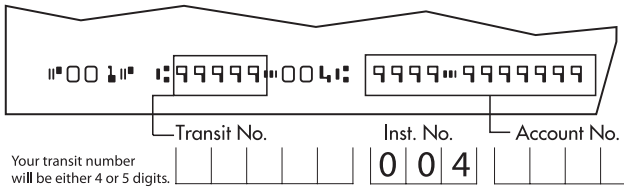
Section 6 - Addition/Change of Banking Information for Direct Deposit of Claims

Bank's Name _____ Effective Date _____ (mm/dd/yyyy)

Bank's Address: _____

Bank's Phone Number: _____ Account Number: _____ Institution Code: _____ Bank Transit Number: _____



Your transit number will be either 4 or 5 digits.

0 0 4

PLEASE ATTACH A VOID CHEQUE or STAMPED BANK DOCUMENT. This is a requirement for processing your direct deposit request.

Section 7 - Change of Provincial Prescription Drug Coverage Registration

For residents of British Columbia, Manitoba and Saskatchewan only

❑ I am now registered for the Provincial Drug Program of: ❑ British Columbia ❑ Manitoba ❑ Saskatchewan

Note: Please attach a copy of the Provincial Ministry letter or documentation that provides proof of registration.

❑ I am no longer registered for my Province's Provincial Drug Program

Section 8 - Other Changes

Plan Member Certification and Authorization

Please sign and date this form to authorize the changes.

I hereby certify all the information provided on this form is true, correct and complete.
The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and/or Equitable Life, collected on this Form and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Form, the Group Insurance Policy and all benefits thereunder, and any supplementary documents. I understand and authorize that for the above purposes the personal information on this file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by, Equitable Life, any drug pooling entity, its sales and distribution network participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians and dentists, and any other person or party whom I authorize.
If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I hereby certify that all of the information provided above is current and accurate. I authorize the use of my S.I.N. for identification purposes and designate the beneficiary as stated above.

Signature of Insured/Plan Member _____ Date _____ (mm/dd/yyyy)

IMPORTANT: PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY.
Incorrect or incomplete information will result in denial or improper payment of your claims.

For the purposes of this Group Insurance Policy, "Spouse" means:
(a) the legally married husband or wife of the Plan Member, or
(b) a person of the same or opposite sex who resides with the Plan Member in a conjugal relationship and is publicly represented as the partner of the Plan Member.

"Dependent" means EITHER a spouse as defined above, AND/OR a natural child, stepchild, adopted child and child that you have been granted final guardianship or custody of by an order of the Court, normally residing with you, or your spouse.

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Section 1 - Notification of Marriage or Partnership Relationship

- Check the appropriate box: Marriage or Partner Relationship*
- Indicate the exact date of marriage, or the date you began living as partners in a conjugal relationship and publicly represented him/her as your partner. For Partner relationships: Please note you cannot provide coverage to your legal spouse (if applicable) and your partner concurrently.
- Indicate Spouse's/Partner's Full Name and Date of Birth
- If you now require a change to your Group Benefits be sure to complete Section 3, Application for Change in Coverage.

Section 2 - Notification of Change of Name

- Indicate previous first and last name and current first and last name.
- Indicate the reason for change (eg. Divorce, marriage), and your new marital status, if applicable.

Note: If the reason for this name change also causes a change to your requirements for group benefits (e.g. adding or deleting dependents), be sure to advise Equitable Life. (Refer to section 3 below).

Section 3 - Application for Change in Coverage

*Forfeiture/*Coordination of Health and/or Dental Benefits

- Indicate the names and dates of birth of all dependents requiring coverage and their relationship to the employee (example: Jane Smith-Spouse, Susan Smith- Child).
- Indicate the reason and the effective date for the change (example: Marriage, Divorce, New Child, Employment Change, Child no longer a dependent).

If you are covered for Health and/or Dental through your spouse's employer, the following may apply:

(a) *Forfeiture of Health and / or Dental Benefits – You may opt out of Health and / or Dental Benefits on this plan by completing the appropriate Section(s) on this form.

Note: This section is also to be completed if you have a dependent (such as a spouse, partner or child) who is covered under another plan, but you require Health and / or Dental coverage for YOURSELF only.

(b) *Coordination of Health and Dental Benefits – Coordination of Benefits allows you to submit claims under one plan and submit any remaining unpaid amount to the other insurance carrier.

Note: Canadian Life and Health Association Regulations Stipulate:

- A spouse/partner must submit claims to his/her employer's plan FIRST.
- Claims for insured children must first be submitted to the plan insuring the spouse/partner whose date of birth is the earliest in the calendar year. If both spouses/partners were born in the same MONTH, the earlier DAY would be the rule.

NOTE: CHANGES IN SECTIONS 1, 2 OR 3 MUST BE AUTHORIZED BY YOUR GROUP PLAN ADMINISTRATOR.

Section 4 - Declaration Appointing Beneficiary

- Indicate the full name and relationship of the Beneficiary(ies) to you in the space provided.
- You have the right to change the Beneficiary at any time; however, where Quebec law applies, the beneficiary designation for your spouse must be designated as revocable to reserve this right.
- If, in the event of a claim, the Primary Beneficiary is also deceased, policy proceeds will be payable to the appointed Contingent Beneficiary, otherwise as required by provincial law.
- If more than one Beneficiary is appointed, proceeds will be payable in equal shares, unless you indicate otherwise.
- If the appointed Beneficiary is under the age of majority, a Trustee of legal age should be appointed. If a Trustee is not appointed, proceeds will be paid as required by provincial law. The full name of the Trustee and the Trustee's relationship to you are required. The Trustee for a Contingent Beneficiary cannot be the Primary Beneficiary.

  Note: You cannot appoint yourself as trustee or as beneficiary.

Section 5 - Change of Address / Email address

- Use this space to advise us of an address change.

Section 6 - Addition/Change of Banking Information for Direct Deposit of Claims

- Include a VOID cheque to allow for processing of the Direct Deposit

Section 7 - Change of Provincial Prescription Drug Coverage Registration

- Indicate whether you are registered for your Provincial Drug Program
- If you are indicating that you are registered, please check off your province of residence
- Attach a copy of the Provincial Ministry letter or documentation that provides proof of registration

Section 8 - Other

- Use this space to advise us of other changes not addressed in the rest of this form