

Group Benefits ~~±~~e-Application for Change

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

1 General information We require this information to process your request. To be completed and signed by plan sponsor.	Plan contract number(s) 83713	Plan member certificate number	Plan sponsor Okanagan College
	Plan administrator name		Plan administrator telephone number (250) 762-5445 Ext.
	Plan member name (last, first, middle initial)		
I <u>certify</u> that the plan member listed above is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.			
Plan administrator signature			Date signed (dd/mmm/yyyy)
2 Plan member name change	New name (last, first, middle initial)		
3 Plan member address	Address (number, street, apt. number)		
	City	Province	Postal code
4 Addition of benefits A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines. *Please enter the date that the common-law cohabitation began in the "Date commenced" field.	Addition of Extended Health Care I wish to ADD Extended Health Care for		Addition of Dental Care I wish to ADD Dental Care for
	<input type="radio"/> Myself ONLY <input type="radio"/> Myself AND 1 dependant <input type="radio"/> Myself and 2 or more dependants <input type="radio"/> My dependants ONLY (I am already covered)		<input type="radio"/> Myself ONLY <input type="radio"/> Myself AND 1 dependant <input type="radio"/> Myself and 2 or more dependants <input type="radio"/> My dependants ONLY (I am already covered)
	<input type="radio"/>		
	Marriage		
	Date of marriage (dd/mmm/yyyy)		
	<input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	

6 Termination of dependent coverage

<input type="checkbox"/>		
<input type="checkbox"/>		<input type="checkbox"/>

<input type="checkbox"/>	
<input type="checkbox"/>	

	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

				<input type="checkbox"/>		
				<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>

1 Plan member signature

Please sign and date here.