Equitable Life of Canada®

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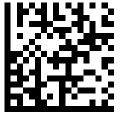

GROUP PLAN MEMBER CHANGE FORM

PLAN MEMBER INFORMATION Complete all sections that apply to you.	
Name of Policyholder	Policy number
Plan Member's name (first, middle, last)	Certificate number

1. NOTIFICATION OF CHANGE OF NAME FOR PLAN MEMBER OR DEPENDENT	
From (first, middle, last)	To (first, middle, last)

2. DEPENDENT INFORMATION CHANGE

Provide details of any dependents you are adding, removing, or updating.

For the purposes of this Policy, "Spouse" means: a) your legally married husband or wife, or b) your partner (a person of the same or opposite sex who resides with you in a conjugal relationship and who you publicly represent as your partner). "Child" means: your natural child, stepchild, adopted child, child you have been granted final guardianship or custody of by an order of the Court, or child of your spouse. Your child must normally reside with you or your spouse.

Please include the effective date for the reason of change selected. An example of the effective date of change would be the date of birth of a child, the date of marriage or the date you started residing with your common law partner for cohabitation.

Dependents age 21 and older may be eligible for coverage. Please review and complete Form 441 - Application for Coverage of Dependent Child Over Age 21.

Provincial health coverage is required to be eligible for the group benefits plan under this policy. An example is OHIP, MSP, RAMQ, etc.

Reason for change ☐ Birth of Child ☐ Marriage ☐ Divorce ☐ Cohabitation ☐ Other ___________________________	Effective date (mm/dd/yyyy)

☐ Add **or** ☐ Remove	Name of Dependent	Relationship to Plan Member	Date of birth (mm/dd/yyyy)	☐ Male ☐ Female	Provincial coverage ☐ Yes ☐ No
☐ Add **or** ☐ Remove	Name of Dependent	Relationship to Plan Member	Date of birth (mm/dd/yyyy)	☐ Male ☐ Female	Provincial coverage ☐ Yes ☐ No
☐ Add **or** ☐ Remove	Name of Dependent	Relationship to Plan Member	Date of birth (mm/dd/yyyy)	☐ Male ☐ Female	Provincial coverage ☐ Yes ☐ No
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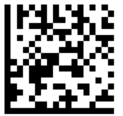


3. YOUR SELECTIONS FOR HEALTH AND DENTAL BENEFITS

Note: reductions in coverage can only be made if you or your dependents have coverage elsewhere, and details must be provided below.
To apply for an increase in coverage, you must submit this form within 31 days of that other coverage terminating.
If you submit this more than 31 days after the termination of that coverage, evidence of insurability will be required (form 452), and a restriction may be placed on some or all benefits.

Health	Dental	
☐	☐	Myself only. I am single or my dependents have coverage elsewhere
☐	☐	Myself and 1 dependent (spouse or child)
☐	☐	Myself and 2 or more dependents (spouse and child(ren))
☐	☐	None, because my dependents and I (if applicable) have coverage under another plan

4. COORDINATION OF BENEFITS

Does your spouse/children have health coverage under their own insurance plan? ☐ Yes ☐ No
Name of other carrier:

Does your spouse/ children have dental coverage under his/her own insurance plan? ☐ Yes ☐ No
Name of other carrier:

You can submit claims under one plan and submit any remaining unpaid amounts to the other plan.

NOTE: Canadian Life and Health Insurance Association Regulations stipulate:

- A spouse/partner must submit claims to his/her own plan first.
- Claims for insured children must first be submitted to the plan insuring the spouse/partner whose month of birth is the earliest in the calendar year. If both spouses/partners were born in the same month, the earlier day would apply. Provide the name of your spouse's/partner's insurance carrier where indicated.

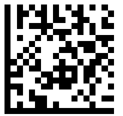
☐ Remove coordination of benefits effective ________________ (mm/dd/yyyy) my spouse/child(ren) no longer has coverage for: ☐ Health ☐ Dental.

5. PLAN ADMINISTRATOR AUTHORIZATION

All changes in Section 3 need to be authorized by your Plan Administrator.

Plan Administrator signature ______________________

Date (mm/dd/yyyy) ______________________



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6. CHANGE TO BENEFICIARY DESIGNATIONS

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. **By providing updated beneficiary information below, you are revoking the previously appointed Primary and Contingent beneficiary(ies).**

Full name of Primary Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:
Full name of Primary Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:

If the above Primary Beneficiary(ies) pre-deceases me, proceeds of the policy shall be payable to the following Contingent Beneficiary(ies):

Full name of Contingent Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:
Full name of Contingent Beneficiary (first, middle, last)	Relationship to Plan Member	Gender: ☐ Male ☐ Female	% Share:

If the beneficiary(ies) is/are under the age of majority at the time of my death, proceeds of the policy shall be payable to the following except in Quebec:

Name of trustee for beneficiary(ies): ____________________

Relationship of Trustee to Plan Member: ____________________

For Quebec Residents only: 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

7. CHANGE OF ADDRESS

New mailing address: (number, street and apartment)		City
Province	Postal code	Effective Date (mm/dd/yyyy)

8. ADDITION/CHANGE TO DIRECT DEPOSIT & EMAIL NOTIFICATION INFORMATION

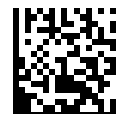
I authorize Equitable Life to deposit group claim payments directly into my bank account.

Bank name	Effective date of change (mm/dd/yyyy)
Bank transit number	Bank number
Account number	

0001
DATE
PAY TO THE ORDER OF: $
DOLLARS
FOR:
SAMPLE
⑆12345⑈012⑆ 1234⑈56789
Transit No. Bank No. Account No.

Email address

I understand that by providing my email address to Equitable Life, I will receive email notifications when Explanation of Benefits for my claims are available on the EquitableHealth.ca® Plan Member Web Services Site and Equitable Life may send me other communications relating to my Equitable Life Group Benefits.



GROUP PLAN MEMBER CHANGE FORM

9. ADDITION/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 Effective: ____________________
Date (mm/dd/yyyy)

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. Effective: ____________________
Date (mm/dd/yyyy)

10. PLAN MEMBER CERTIFICATION AND AUTHORIZATION

The personal information collected by Equitable Life will be used by Equitable Life for the purposes of underwriting, servicing, managing and administering the group benefits plan, and claims processing and adjudication.

I authorize that for the above purposes the personal information is accessible to, and may be exchanged with, authorized employees of and relevant third parties retained by Equitable Life, its sales distribution network, the group benefits plan administrator, any industry drug pooling entity, participating reinsurers, other insurance companies, investigative organizations, health care providers and facilities, including, but not limited to pharmacies, physicians and dentists, and any other person or party 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 the 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 certify that all of the information given on this form is true, correct and complete.

I designate the beneficiary(ies) stated above.

______________________________ ____________________
Plan Member signature Date (mm/dd/yyyy)