Ensure form is signed and dated.
Plan administrator to keep original and send copy to:
3095 Woodbine Drive, North Vancouver, BC V7R 2S3
Phone (604) 980-6227 • Toll-Free 1-800-432-9707 • Fax (604) 983-2935
Website: www.jbenefits.com

Application for Change

Instructions: Complete only the fields necessary to identify the employee and then only the sections that need changes.

EMPLOYER/PLAN ADMINISTRATOR INFORMATION Plan Administrator to complete applicable sections

Employer Name	Client #	Division #	Department #	Class #	Employee #

Plan Administrator Name	Plan Administrator Phone #
Plan Administrator E-Mail	**Plan Administrator Signature** Date mm/dd/yyyy

CHANGE OF DIVISION, DEPARTMENT OR CLASS

New Division #	New Department #	New Class #	New Employee #	Effective Date: mm/dd/yyyy

CHANGE OF EARNINGS

New Earnings				Hours per week	Commission	Effective Date: mm/dd/yyyy
$	☐ Hourly	☐ Bi-weekly	☐ Weekly			
	☐ Semi-monthly	☐ Monthly	☐ Annually			

CHANGE OF OCCUPATION

Employee's New Occupation	Effective Date: mm/dd/yyyy

EMPLOYEE/PLAN MEMBER INFORMATION - Employee to complete as applicable

Last Name	First Name	Personal Phone #	E-Mail	
Street Address		**City**	**Province**	**Postal Code**

CHANGE OF DEPENDENT INFORMATION

Marital Status	Effective Date: mm/dd/yyyy
☐ Single ☐ Married* ☐ Common-law** ☐ Divorced ☐ Separated	

*** including civil union in Quebec**

****Common-law Declaration**

The policy provides that a person with whom the insured employee has been co-habitating for a period as stated in the policy and who is being represented publicly as the spouse, will be eligible for benefits, provided the employee files with the insurer, the name of the person to be considered the spouse for the purpose of this policy.

For the purpose of this policy, my spouse is: Last Name	First Name	This person has been known as my spouse since

Effective Date: mm/dd/yyyy

Add	Delete		Last Name	First Name	Middle Initial	Sex	Date of Birth MM/DD/YYYY	Full-Time Student (age 21 or older)	Disabled	Name of Educational Institution or Details of Disability*
☐	☐	Spouse				☐ M ☐ F		N/A	N/A	N/A
☐	☐	Child				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	
☐	☐	Child				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	

*** Complete this section if the child is over the age of 21 and attending school full-time or is disabled.**

CHANGE OF SPOUSAL COVERAGE

My spouse is now insured for Extended Health Care benefits and/or Dental Care benefits under his/her employer's plan.

Effective Date: mm/dd/yyyy

My spouse's plan covers:	Extended Health Care	Dental Care
	☐ My spouse only	☐ My spouse only
	☐ My spouse and me only	☐ My spouse and me only
	☐ My spouse and our children only	☐ My spouse and our children only
	☐ My spouse, our children, and me	☐ My spouse, our children, and me

Spouse's Employer	Spouse's Extended Health Care Insurer	Policy #	Spouse's Dental Care Insurer	Policy #

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WAIVER OF BENEFITS*

Effective Date: mm/dd/yyyy

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under your spouse's group insurance plan, you may refuse to be covered for such benefits by selecting the applicable box:

I refuse coverage for myself and my dependents under ❑ **Extended Heath Care** ❑ **Dental Care**

I refuse coverage for my dependents under **Extended Health Care** ❑ **Dental Care**

*** If coverage under your spouse's plan terminates, you have 31 days after the date of the termination to apply for coverage under this plan without evidence of good health. After 31 days you may be required to submit satisfactory evidence of insurability for you and your dependents, at your own expense, and coverage may be denied or restrictions may apply.**

LOSS OF SPOUSAL COVERAGE

Effective Date: mm/dd/yyyy

As a result of the termination of coverage previously available through my spouse, I am now applying for the following benefit(s):

Extended Health Care:	☐ My spouse only	☐ My spouse and myself only	☐ My spouse and our children only	☐ My spouse, myself and our children	☐ n/a
Dental Care:	☐ My spouse only	☐ My spouse and myself only	☐ My spouse and our children only	☐ My spouse, myself and our children	☐ n/a

Reason for Termination

CHANGE OF NAME

Effective Date: mm/dd/yyyy

I hereby request to change my name

From: Last Name	First Name	To: Last Name	First Name

CHANGE OF BENEFICIARY DESIGNATION

Effective Date: mm/dd/yyyy

I revoke all previous appointments of beneficiaries under my group insurance plan and appoint as my beneficiaries:

Last Name	First Name	Middle Initial	Relationship to Plan Member	Age	Percentage*
					%
					%
					%

Percentages must total 100%

For Quebec residents only: In Quebec, the designation of your legal (by marriage or civil union) spouse as the beneficiary is irrevocable unless otherwise specified. If beneficiary designation is irrevocable, the beneficiary's consent is required to change it. **I hereby make the above beneficiary designation revocable:** ☐ **Initial**

CHANGE OF CONTINGENT BENEFICIARY DESIGNATION

Effective Date: mm/dd/yyyy

If there are no surviving beneficiaries at the time of my death, the following contingent beneficiaries shall receive the benefit. If there are no surviving contingent beneficiaries at the time of my death, the benefit will be payable to the ESTATE.

Last Name	First Name	Middle Initial	Relationship to Plan Member	Age	Percentage*
					%
					%

Percentages must total 100%

For Quebec residents only: In Quebec, the designation of your legal (by marriage or civil union) spouse as the beneficiary is irrevocable unless otherwise specified. If beneficiary designation is irrevocable, the beneficiary's consent is required to change it. **I hereby make the above beneficiary designation revocable:** ☐ **Initial**

DECLARATION APPOINTING TRUSTEE **complete if beneficiaries are under the age of majority** (Not applicable in Quebec*)

Effective Date: mm/dd/yyyy

I appoint as Trustee to receive any amount due to any beneficiaries under the age of majority:

Last Name	First Name	Middle Initial	Relationship to Plan Member

*In Quebec, there may be issues with respect to the appointment of a trustee. You should consult a legal advisor regarding this matter.

AUTHORIZATION AND SIGNATURE

I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under my Employer's/Policyholder's group insurance plan and CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my Employer/Policyholder, Johnstone's Benefits and its employees, and the agents, insurers and service providers for the purpose of underwriting, administration, claims processing and the enrollment of myself and my dependents in my Employer's/Policyholder's group insurance plan.

I understand that the insurers maintain a file related to my benefits and that I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

If my Social Insurance Number is used as my identification number, I AUTHORIZE its use for the administration of my group benefits.

If any contributions are required to be made by me with respect to my group benefits, I AUTHORIZE my employer to make any required deductions from my earnings and remit same to Johnstone's Benefits.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

mm/dd/yyyy

Employee/ Plan Member Name	X Employee/ Plan Member Signature	Date

At Johnstone's, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in our offices. We limit access to information in your file to Johnstone's staff, to insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefit plan.

THIS FORM MUST BE SIGNED AND DATED.

JB Internal