

**Employee Change Form**

Please send completed forms to:  
**Kechnie Benefits**  
 262 Queen Street South  
 Kitchener ON N2G 1W3

**Section A- Member Information**

Firm Name		Group Number	Firm Number	Certificate Number
First Name	Last Name		Middle Name(s)	Date of Birth (dd/mmm/yyyy)
Address (number,street,apt. number)			City	Province
				Postal Code

**Section B- Marital Status or Name Change**

New Marital Status		Reason for Marital Status Change	Date of Marital Status Change (dd/mmm/yyyy)
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Common-Law			
Member Name Change Requested	Previous Name	Reason for Name Change	Date of Member Name Change (dd/mmm/yyyy)

**Section C – Terminating an Employee’s Coverage**

Reason for Terminating Employees Coverage	Termination Date (dd/mmm/yyyy)
Plan Administrator/Authorized Signature	Date (dd/mmm/yyyy)

**Section D - Changes to Coverage**

*You may refuse benefits for yourself and dependent(s) **ONLY** if you are covered for similar benefits under your spouses plan. You may apply at a later date for benefits you have refused. Certain conditions will apply. Please see your Plan Administrator for details.*

HEALTH	DENTAL	
<input type="radio"/>	<input type="radio"/>	Single Coverage
<input type="radio"/>	<input type="radio"/>	Family Coverage (complete section D)
<input type="radio"/>	<input type="radio"/>	None, because my spouse has coverage (Please provide name of carrier and effective date of coverage)

Spouse’s Insurance Carrier: \_\_\_\_\_  
 Effective date of Coverage: \_\_\_\_\_

If you had previously waived your health & dental coverage because you were covered under your spouse’s plan, please provide the date that coverage ceased: \_\_\_\_\_

**Section E - Dependent Information**

Dependent’s Full Name	Date of Birth (dd/mmm/yyyy)	Sex (M or F)	Disabled Dependent? (Yes or No)	Full-Time Student? (Yes or No) If yes, name accredited institution
Spouse				
Child				
Child				
Child				

**Section F- Beneficiary Designation**

*I hereby designate the following revocable beneficiary to any Life Insurance benefits payable as a result of my participation in the plan. A trustee must be assigned to beneficiaries less than 18 years of age. If a beneficiary is not assigned, "Estate" will be assumed.*

**Beneficiary Codes:**

- 1** – Primary Beneficiary *(person or persons who will receive the proceeds of insurance under the policy upon the death of the insured person)*
- 2** – Contingent Beneficiary *(person or persons who will receive the proceeds of insurance under the policy upon the death of the insured person and the primary beneficiary)*
- 3** – Trustee *(person or persons who is the trustee of a beneficiary or contingent beneficiary under the age of 18)*

Name (First, Last)	Contact information (if different than the member)	Relationship to Member	Beneficiary Code	Percentage

**For Quebec residents only**

*If beneficiary is chosen as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation.*

<p>In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.</p> <p>If spouse is beneficiary, designation is:</p> <p><input type="radio"/> Revocable    <input type="radio"/> Irrevocable</p>
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**Section G- Plan Member Signature**

I designate the person(s) named above under Beneficiary Designation as my beneficiary.  
 I certify that the information in this form is true and complete, to the best of my knowledge.  
 If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purposes of determining their eligibility for benefits.  
 If applicable, I authorize my plan sponsor to make deductions from my pay for my group benefits.  
 I understand that coverage changes are subject to the terms of the group insurance plan and any applicable legislation.

Member Signature	Date Signed (dd/mmm/yyyy)
Plan Administrator/Authorized Signature	Date Signed (dd/mmm/yyyy)