Please send completed forms to:

Kechnie Benefits
447 Frederick St – Fourth Floor
Kitchener ON N2H 2P4
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

Group Benefits
Employee Change Form

Section A- Member Information

Plan Sponsor	Group Number	Firm Number	Certificate Number

First Name	Last Name	Middle Name(s)	Date of Birth (dd/mm/yyyy)

Address (number,street,apt. number)	City	Province	Postal Code

Section B - Name Change

Previous Name	Reason for Name Change	Date of Member Name Change (dd/mm/yyyy)

Section C – Addition or Deletion of Coverage

You may refuse benefits for yourself and dependent(s) ***ONLY*** *if you are covered for similar benefits under your spouse's plan or under another group benefit plan. You may apply at a later date for benefits you have refused after experiencing a life event (E.g. Loss of spouse's benefits).* ***Requests received more than 30 days past a life event date, OR received when there is NO Life Event, are subject to the provision of evidence of insurability for medical underwriting and subsequent approval of coverage by the insurance carrier (Please note Approval of Coverage is NOT Guaranteed). If approved, a Dental restriction of $250/first 12 months is applied.***

HEALTH	DENTAL	TYPE OF COVERAGE	REASON FOR CHANGE	MEMBER INITIALS
☐	☐	Single Coverage	◯ Marital Status/Common-law ◯ Spouses Coverage Cancelled ◯ Other: _____	Please initial herein to acknowledge you have read and understand the information outlined in *Section C – Addition or Deletion of Coverage*, and to confirm you would like to proceed in making this change to your plan: _____
☐	☐	Couple Coverage		
☐	☐	Family Coverage (complete section E)	Effective Date:_____	
☐	☐	None, because my spouse has coverage **(Please provide name of carrier and effective date of coverage)**	Spouse's Insurance Carrier: _____ Effective date of Coverage: _____	

Section D - Dependent Information

Dependent's Full Name	Date of Birth (dd/mm/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 E – Terminating an Employee's Coverage

Reason for Terminating Employees Coverage	Termination Date (dd/mm/yyyy)

Plan Administrator/Authorized Signature	Date (dd/mm/yyyy)

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

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

If spouse is beneficiary, designation is: ◯ Revocable ◯ Irrevocable

Section G- Acknowledgements & 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 confirm that 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.

I acknowledge that if I am refusing benefits for myself/dependents it is because I/We are covered for similar benefits under my spouse's plan or under another group benefits plan. I understand that I may apply at a later date for benefits that I have refused after experiencing a life event (E.g. Loss of spouse's benefits). **Further to this, I acknowledge that requests received more than 30 days past a life event date, OR received when there is NO life event, are subject to the provision of evidence of insurability for medical underwriting purposes, subsequent approval of coverage by the insurance carrier, and that approval of coverage is NOT guaranteed. I acknowledge that if approved, a Dental restriction of $250/first 12 months is applied.**

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

For Kechnie Office Use Only:

Date Received:_____ Date Processed: _____ Administrator Initials:_____