



Change in Marital Status

Member			
First name		Last name	

Member Contact Information			
Personal email			
Street address			
City, Province		Postal Code	
Home phone		Mobile phone	

Change in Status	
attach copies of supporting legal documents such as marriage certificate, separation agreement, death certificate etc	
Reason for Change	New Status
<input type="checkbox"/> got married <input type="checkbox"/> common-law <input type="checkbox"/> spouse passed <input type="checkbox"/> separated <input type="checkbox"/> divorced	<input type="checkbox"/> married <input type="checkbox"/> common-law <input type="checkbox"/> single <input type="checkbox"/> divorced
Date of Change	

Member's New Family Information				
Spouse's first name		Spouse's last name		
Date of birth		Gender	S.I.N.	
Spouse – the person to whom you are legal married; or a person continuously living with you in a role like that of a marriage partner for at least one year.				

Dependent Child First name	Dependent Child Last name	Gender	Date of Birth	If over age 21 is child a student?
Dependent Child – your natural or legally adopted child, (dependent on you or your spouse for financial support), or step child, who is: unmarried; under age 21, or under age 25 and a full-time student; not employed on a full-time basis; and not eligible for insurance as an employee under this or any other group benefit program.				

Benefits Modules

The ELCIC Group Benefits Plan offers member the choice between three modules, each comprising different levels of benefits coverage. Due to you change in marital status you have the opportunity to revise your benefits module selection.

Blue Green Teal

Please advise your employer of your selection and confirm who is responsible for the difference in premium. If it is your responsibility then payment is made by payroll deduction.

Coordination of Benefits

Does your new spouse have health and dental benefits plan through a current employer that includes coverage for you and your dependents?

No Yes If yes please indicate for which health dental

If **yes**, you will be coordinating your benefits with those of your spouse. Coordination of benefits allows for reimbursement of insured expenses from both yours and your spouse's plans, up to a total of 100% of the actual expenses incurred.

Spouse's benefits insurer		Effective date of spouse's coverage	
Spouse's insurance plan number		Spouse's member number	

Life Insurance Beneficiary

First name	Last name	Date of birth	Address	Relationship	S.I.N.	% share

Trustee Appointment for Minors

Trustee appointment for minors – please complete if any beneficiaries are under 18 years of age

First name	Last name	Phone number	Address	Relationship

If living, shall be and is hereby appointed trustee to receive and disburse any monies payable hereunder to child(ren) aforesaid during minority, or failing such trustee, to the duly appointed guardian of such minor child(ren) as trustee. Payment so made to said trustee shall discharge the payer to the extent of such payment.

Authorization and Acknowledgements

I certify the information contained herein is correct. I request my employer to arrange for the issuance of group coverage for which I am eligible. I understand that if I have a spouse and/or eligible dependents, I will automatically be enrolled with family coverage. I authorize my employer to deduct from my earnings the premiums, if any, required for the coverage.

I consent to the collection, use and disclosure by ELCIC Group Services Inc. (GSI) of my personal information, including without limitation the information provided in this form, in accordance with GSI's Privacy Policy, including without limitation for the purpose of activities related to my enrollment in and ongoing eligibility for this group benefits plan, the efficient administration of my entitlements under the benefits plan, and the management of my participation in the benefits plan.

I consent to GSI disclosing and/or obtaining information to and from the subscribing employer, and to its agents and service providers, including, but not limited to insurers, benefits providers or administrators and benefits consultants, for these purposes.

I am authorized to release information concerning my spouse and my dependents.

I hereby revoke all previously designated beneficiaries and appoint the aforesaid to receive any benefits payable in the event of my death, subject always to the provisions of any law or government regulations. In the absence of a new beneficiary designation made by me and duly filed with the administrator under this plan, this beneficiary designation shall be valid.

I understand that I have the right to access the personal information in my file, and if necessary, correct any inaccurate information.

Member signature		Date	
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I confirm we have made the appropriate updates to this member's enrollment in our payroll records.

Employer signature		Date	
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