## **Change Form**

## Group Benefit Plan - Grandir ensemble - Great-West Life - Policy 165729

Name of Childcare Cente	r:							
Effective date of change:	(day /month /year)							
1. Participant information	on							
Name:	n member ID							
2. Reinstatement follow	ring an approved leave of absend	ce (maximum of 6 months; Summer = 2.5 month	s): Annual salary (upon return to work)					
Plan member returned to	work on: Day Month _	Year	\$					
Reason for reinstatement	(Return from approved leave of absen	ice, ex. summer leave)						
3. Name change								
From:		to:						
Given Name	Surname	Given Name	Surname					
Health and/or dental coverage can only be refused if you are covered by duplicate group benefits through your spouse's employer.  I understand the plan of group benefits offered to me, but I decline to participate in:  Extended Health care:								
You can opt out of the heather them at a later date, you wascepted.	<del>-</del>	ependents even if they are not covered elsevillity to the insurer (at your cost) and the covered elsevillet to participate in:						
Dental care:	my dependants only							

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Plan member name:				GWL Plan member ID :				
6. Addition of grou	p health and dental bend	efits						
	ave coverage for yourself of the loss of coverage.	and/or your depende	ents if you lose you	ur coverage	with your spo	ouse. This re	quest must be	
Effective date of loss	of coverage through spou	usal plan: Day	Month		_Year			
☐ Extended Healt	th care	Dental care						
7. Dependant infor	mation change							
This section must be	completed if you are addi	ng or deleting a depe	endant, or updatin	g dependant	information.			
Effective date of char	nge : Day	Month		Year				
Changed to a:			☐ Family coverage		☐ Life insurance coverage only			
Reason:	☐ Birth of child	☐ Marriage		☐ Separation / Divorce				
☐ Cohabitation		Date of marri	Date of marriage/cohabitation Day		Month	Year		
Other (please specify	/)							
Spouse information:  Date of birth (day/mo			Given Name	Sex:	Surname Male	Fem	ale	
What group benefits	coverage does your spou	se have through his/h	ner employer?					
		amily amily	Waived		None			
Where applicable, b	penefit payments will be	coordinated betwee	en this plan and y	our spouse	e's plan.			
Dependants' informa  Add Change De	lete			ate of birth month/year	Sex M / F	Full time student Yes	Disabled Yes	
	Given name	Surname						
	Given name	Surname						
	Given name	Surname						
	Given name	Surname						
Authorizations and	declarations							
	mation given is true, corre opy or electronic copy of t				lid as the orio	jinal.		
Plan member's signa	uture:		Dat	e:				
Employer's signature	o:		Dat	e:				