



IATSE 891 | ACTIVE HEALTH PLAN

Return to:
J & D Benefits Inc.
 8901 Woodbine Ave., Suite 228
 Markham, ON L3R 9Y4
 TEL: 1-800-218-7018 FAX: 905-477-2249

GROUP BENEFITS CHANGE FORM

Member Name <small>First Middle Init. Last</small>	Union ID #
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Please complete **ONLY** the sections below with the information you wish to change, then sign and date the form

NAME/ ADDRESS CHANGE	New Name	<small>First Middle Initial Last</small>					
	New Address	<small>Apt # Street</small>					
		<small>City</small>		<small>Province</small>	<small>Postal Code</small>		
		<small>Email address</small>					
	Effective Date of Change	M	D	Y	Gender Change	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> GNC/NB <input type="checkbox"/> Undisclosed

CHANGE IN BENEFIT COVERAGE	I wish to change my status to: <input type="checkbox"/> Single <input type="checkbox"/> Family						
	Reason for change	<input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Common-law (provide date you began living together) <input type="checkbox"/> Coverage under spouse's plan terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Other (provide explanation) _____				Date of change	
						M	D

SPOUSE INFORMATION		First Name	Middle Initial	Last Name (only if different from member)	Sex	Date of Birth
	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> Female <input type="checkbox"/> Male	M D Y
	<input type="checkbox"/> My spouse does not have extended health and/or dental coverage		<input type="checkbox"/> My spouse has the following benefits:		Extended Health: <input type="checkbox"/> Single <input type="checkbox"/> Family Dental: <input type="checkbox"/> Single <input type="checkbox"/> Family Name of Insurance Company: _____ Effective Date of Spouse's Benefits: _____ Policy #: _____ ID#: _____	

SECTION 2 DEPENDENT INFORMATION <i>Please list all dependents.</i>		First Name	Last Name <small>(only if different from employee)</small>	Gender	Date of Birth	For children age 21 or older please specify:						
	Child			<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> GNC/NB <input type="checkbox"/> Undisclosed	M D YYYY	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"><small>Full time student</small></td> <td style="width:50%; text-align: center;"><small>Disabled Dependent</small></td> </tr> <tr> <td style="text-align: center;">Yes <input type="checkbox"/></td> <td style="text-align: center;">Yes <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Name of School and ID# _____</td> </tr> </table>	<small>Full time student</small>	<small>Disabled Dependent</small>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Name of School and ID# _____	
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Yes <input type="checkbox"/>	Yes <input type="checkbox"/>											
Name of School and ID# _____												

If you have additional dependents please list them on a separate sheet and attach to this form.

Member Name <i>First Middle Initial Last</i>	Union ID #
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BENEFICIARY DESIGNATION <i>Beneficiary(ies) designated on this form will replace any beneficiaries designated on previous group enrolment or change forms</i>	First name	Last name	Relationship	Date of Birth	%	
	FOR QUEBEC MEMBERS: Where Quebec law applies and you have designated your married or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable", below. I hereby make the above beneficiary designation: <input type="checkbox"/> Revocable, I may change this beneficiary designation at any time. If changing an irrevocable beneficiary, the beneficiary being removed must sign below. Irrevocable beneficiary's signature: _____ Date: _____					
	TRUSTEE DESIGNATION: Complete only if designating a beneficiary who is a minor or who lacks legal capacity. It is recommended that you consult with a legal advisor, and with any proposed trustee/administrator. For Quebec Applicants Only – Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity will be paid to his/her tutor(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and the Plan Administrator has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section.					
	Trustee full name	Relationship	Date of Birth			

MEMBER AUTHORIZATION AND COMPANY DECLARATION This section MUST be signed and dated in INK by the plan member	<p>At J&D Benefits Inc., the personal information we collect concerning you and your dependents is kept in strict confidence and used only for the purposes you have authorized. Your personal file will be kept at J&D Benefits Inc.'s (J&D) offices. You have the right to request access to your personal information and, if necessary, correct any inaccurate information and/or make changes to current information whenever necessary. In order to do so, send a written request to J&D Benefits Inc., 8901 Woodbine Avenue, Suite 228, Markham, ON, L3R 9Y4.</p> <p>Access to your personal information will be limited to J&D's employees and providers in the performance of their jobs, individuals to whom you have consented access, and persons authorized by law. For the purposes of audits and administrative reporting, J&D may release your Policyholder statistical financial information without personal identifiers.</p> <p>I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.</p> <p>If changing information on my spouse and/or dependent children, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their coverage under my Plan Sponsor's group plan.</p> <p>On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my plan sponsor and J&D Benefits Inc., its employees, agents, reinsurers and service providers for the purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my plan sponsor's group insurance plan.</p> <p>I AGREE that a photocopy of this authorization shall be as valid as the original.</p>	
	Member Signature:	Date Signed: