BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Group Insurance Changes

The appropriate section(s) below should only be completed as changes to the reverse side are required. **Please return this form to your District Benefits Administrator once completed.** EMAIL THIS *SIGNED* FORM TO **benefits@sd61.bc.ca.** The benefits administrator should file this form for future reference.

Part 1: Employee Identification

Employee's Last Name	First Name	Initial	ID Number	Provincial Health Plan Number (Care Card)

Part 2: Change in Family Status

Change of coverage requested due to the following "event":

☐ Marriage ☐ Cohabitation ☐ Divorce ☐ Separation ☐ Death ☐ Birth ☐ Adoption

☐ Other (specify):

Date of Event (M/D/Y)

Revised Extended Health Coverage	Revised Dental Coverage
○ Single ○ Couple ○ Family ☐ Waived (attach Waiver of Coverage form; required for any termination)	○ Single ○ Couple ○ Family ☐ Waived (attach Waiver of Coverage form; required for any termination)

Add / Delete (If deleting a dependent, a waiver of coverage form will also be required)		Dependent's First Name (Spouse and/or Children)	Initial	Last Name (if different from Employee)	Birth date (MM/DD/YYYY)	Relationship (Married, Common Law, Minor (age 0-21), Student (age 22-25))	Gender (M – Male, F – Female, X – Another Gender, U – Prefer Not to Disclose)	Provide name of school **and student number** if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
○	○							
○	○							
○	○							
○	○							

Part 3: Change to Spousal or Other Coverage

Change of ☐ Dental ☐ Extended Health coverage requested due to:

Date of Change (M/D/Y)

○ Spouse's plan terminated – enroll on BCPSEA plan (ensure Group Insurance Application is up to date or note additions on this form)
You must include documentation from the previous benefits plan/policy indicating the termination date of coverage

○ Transferring to Spouse's plan - terminate from BCPSEA plan by completing Waiver of Coverage Form. Spouse's policy number: _____

Revised Extended Health Coverage:	Revised Dental Coverage:
○ Single ○ Couple ○ Family ☐ Waived (attach Waiver of Coverage form)	○ Single ○ Couple ○ Family ☐ Waived (attach Waiver of Coverage form)

Part 4: Change of Beneficiary Designation THIS SECTION NOT APPLICABLE FOR BCTF/GVTA APPLICANTS

New Beneficiary - Last Name	First Name	Initial	Share of Proceeds %	Relationship	Name of Trustee for Beneficiaries Under 18
			%		
			%		

To which benefit(s) does this change apply? ☐ All applicable benefits, or: ☐ Basic Life ☐ Optional Life ☐ Basic AD&D ☐ Optional AD&D

Part 5: Change of Name

Previous Last Name	First Name	Initial	Date of Change (M/D/Y)
New Last Name	**First Name**	**Initial**	☐ Employee ☐ Dependent

Part 6: Change of Employee's Address IF YOU CHANGED YOUR ADDRESS DIRECTLY ON THE PBC WEBSITE THIS FORM IS NOT REQUIRED

Apt / Unit Number	Street Address	Date of Change (M/D/Y)

City	Province	Postal Code	Phone Number ( )

I hereby confirm the above information is complete, true and correct. **I understand that if this application is completed more than 31 days after any change in family status, satisfactory evidence of insurability will be required to add dependents to this plan.** I reserve the right to change my beneficiary at any time.

Employee Signature _____ Date Signed (M / D / Y) _____

Acceptable signatures include: 1) Print and sign in ink or 2) Save the form as a PDF and sign with a digitally drawn signature. (not typed, nor a handwritten font style)