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Group Operation
P.O. BOX 1640, Windsor, ON N9A 0C8, 1-800-665-7076

Group Benefits
Notice of Change Form

Instructions:

Please complete this form to report changes to your group Insurance enrollment information.
Follow these instructions carefully as incorrect or incomplete information could result in denial or incorrect payment of your claims
Please print clearly. Do not erase or use any type of correction fluid. If an error is made, cross out and initial.

1. To Change your Marital Status, please complete the Identification Section, plus Sections 1, 2, 4 (if required) and 7.
2. To Add or Remove Dependents, please complete the Identification Section, plus Sections 2 and 7.
3. To Change your Name, please complete the Identification Section, plus Sections 3 and 7.
4. To Refuse Health and/or Dental Benefits, please complete the Identification Section, plus Sections 4 and 7.
5. To Refuse All Benefits under a Voluntary Plan, please complete the Identification Section, plus Sections 2, 5 and 7.
6. To Change your Beneficiary, please refer to our separate change of Beneficiary Form.

When complete, this form can be returned to your plan administrator or send directly to Wawanesa Life, Group Operation.

Identification:

Employer Name: _____ Group # G _____

Employee Name: _____ _____ Claimant # WLI _____
Last Name First Name

Section 1: Change of Marital Status

A) ☐ Married Date of Marriage: _____ (**Year/Month/Day)**

☐ Common-Law Commencement Date of Common-Law Relationship: _____ (**Year/Month/Day)**

Please indicate one of the following:

☐ I am requesting coverage for my spouse and/or my dependent children. Section 2 must also be completed.
☐ I do not need coverage for my spouse and/or my children.

B) ☐ Separated Date of Separation: _____ (**Year/Month/Day)**

☐ Divorced Date of Divorce: _____ (**Year/Month/Day)**

☐ Widowed Date Widowed: _____ (**Year/Month/Day)**

Please indicate if one of the following is applicable:

☐ I no longer require coverage for my spouse. Section 2 must also be completed.
☐ I no longer require coverage for my dependent children. Section 2 must also be completed.
☐ I am legally required to continue coverage for my ex-spouse. Please provide a copy of the court order.

Section 2: Add or Remove Eligible Dependents

A) Please provide all details for eligible dependents that you wish to **add or delete** to your Group Insurance Coverage.
Note: If coverage was previously waived for an eligible dependent, completion of an Alternate Coverage Form is also required

						Birth Date	*Other Insurance	
Add or Delete		**Last Name**	**First Name**	**Initial**	**Sex**	**(Year Month Day)**	**Health**	**Dental**
	Spouse							
	1st Child							
	2nd Child							
	3rd Child							
	4th Child							

***Other Insurance: Co-ordination of Benefits**

- If your family members have insurance coverage under any other plan providing similar benefits, your benefits will be coordinated with the other plan(s). Claims will be coordinated according to industry guidelines so that the total payments under all plans do not exceed 100% of the total eligible expenses.
- You must declare other coverage by completing the Other Insurance columns for dependents covered under another plan.
- If your spouse has other coverage, place an S (Wawanesa plan is considered the Secondary plan) in the Other Insurance column.
- For dependent children eligible under your spouse's plan, place an S if your birth date falls later in the year than the birth date of your spouse. (e.g. If your birth date is in June and your spouse's birth date is in March – place an S in the Other Insurance Column)
- In situations of divorce or separation, if you have custody of a dependent child, the Wawanesa plan will be considered the Primary (first) plan. If you do not have custody, and other insurance coverage exists for this child, place an S in the Other Insurance column. (The plan of the parent with custody of the child will be the Primary plan).

FOR EXECUTIVE OFFICE USE ONLY

Group Operation
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Group Benefits
Notice of Change Form

Instructions:

Please be advised that my name has changed From:

Last Name _____ First Name _____ Initial _____

To:

Last Name _____ First Name _____ Initial _____

Effective: _____ (**Year/Month/Day)**

The Reason for the Name Change: ☐ Marriage ☐ Divorce ☐ Other

Note: A Change of Name due to a change in Marital Status may also require a change in Dependent coverage. Please review Sections 1 and 2.

Section 4: Refusal of Health and/or Dental Benefits

I have been offered the opportunity to join the firm's Group Insurance Plan and the benefits provided by this Plan have been explained to me. However, I **decline** to participate in the following benefits:

I decline Extended Health for:	☐ Myself and my dependents ☐ My dependents ONLY	**I decline Vision for:**	☐ Myself and my dependents ☐ My dependents ONLY	**I decline Dental for:**	☐ Myself and my dependents ☐ My dependents ONLY

Note: Coverage can only be refused for the above benefits if you and/or dependents are covered by similar group benefits through your spouse's employer.

Name of Spouse's Insurer _____ Plan Number _____

If you lose spousal coverage, you **must** apply for coverage under this Plan within 31 days of loss of such coverage.
If you apply for coverage after the 31 days, you may be required to provide evidence of insurability and your dental benefits will be restricted.

Section 5: Refusal of All Benefits – For Voluntary Plans Only

I have been offered the opportunity to join the firm's Group Insurance Plan and the benefits provided by this plan have been explained to me. However**, I decline to participate in ALL BENEFITS**

Pease date and sign below to indicate your refusal to participate in the Group Insurance Plan.

Date: _____ Signature: _____

If you wish to join the plan at a later date, you will be required to provide evidence of insurability and your dental benefits will be restricted.

Section 6: Consent, Disclosure

Consent & Disclosure Regarding Personal Information

I consent to Wawanesa Life collecting, using and disclosing my personal information for the purposes of: establishing and maintaining communications with me; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law.

I understand that Wawanesa Life may share my personal information with the following people, organizations and service providers: Wawanesa Life employees and agents who require this information to perform their jobs; claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies; people to whom I have granted access; and people who are legally authorized to view my personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions.

I acknowledge that I only enroll, at this time or any future time, dependents who have authorized me to provide their information and consent to the collection, use and disclosure of that information for the purposes listed above.

I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the claim being applied for.
You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from the Wawanesa Life Executive Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

If you have a question (including a question concerning our collection of personal information, or the collection, use, disclosure or storage of personal information by service providers outside Canada on our behalf) or complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance: Privacy Officer, The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8.

Section 7: Authorization & Acknowledgement

Authorization & Acknowledgement

- I hereby apply for coverage for which I am, or may become eligible under the Group Insurance Plan issued by Wawanesa Life.
- I acknowledge that the information provided is complete and accurate.
- I authorize the deduction from my pay for any contributions required under the Group Insurance Plan, if required.
- I authorize Wawanesa Life, any healthcare provider, my plan administrator, other insurance companies, or benefit providers working with Wawanesa Life to exchange information, when necessary to determine my eligibility for coverage and to administer the Group Insurance Plan.
- I acknowledge that I have read the Consent & Disclosure regarding Personal Information and consent to my personal information being used in such a manner.

Date: _____ Signature: _____