Group Division
400 – 200 Main Street, Winnipeg, MB R3C 1A8

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 Division.

Identification:

Employer Name: ______________________ Group # G__________

Employee Name: ______________ ______________ Certificate # 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** 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	
	Last Name	**First Name**	**Initial**	**Sex**	**(Year Month Day)**	**Health**	**Dental**
Spouse							
1st Child							
2nd Child							
3rd Child							
4th Child							
5th Child							

B) Please provide all details for eligible dependents that you wish to **remove** to your Group Insurance Coverage.

					Birth Date	*Other Insurance	
	Last Name	**First Name**	**Initial**	**Sex**	**(Year Month Day)**	**Health**	**Dental**
Spouse							
1st Child							
2nd Child							
3rd Child							
4th Child							
5th Child							

* For an Explanation of "Other Insurance", see Page 2

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Section 2: Add or Remove Eligible Dependents (Continued)

***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).

Section 3: Change of Name

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 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.

Spousal Insurer's Name: ______________ Plan Number: ______________

If you lose spousal coverage, you **must** apply for coverage under this Plan within 31 days of loss of coverage. If you apply for coverage after 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: Notice Concerning Personal Information

You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.
You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 200 - 191 Broadway, Winnipeg, MB R3C 3P1 or at www.wawanesalife.com

Section 7: Authorization & Acknowledgement

I understand that any changes indicated on the Change Form will not take effect unless this form is received and validated by Wawanesa Life. Changes not reported within 31 days of their effective date may require additional documentation before coverage or changes in coverage can commence.

Date: ______________ Signature: ______________

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Recorded by The Wawanesa Life Insurance Company this __________ day of ______________________, ______________.

Validated by: ____.