



NOTICE OF ADDITION/CHANGE/TERMINATION

- To submit change(s), make a photocopy of this form and send by FAX to the BSIA
- MAIL the original copy to the BSIA
- Make a photocopy of this form & keep it with the employee's personal file
- Section 1 of this form must be completed for all changes

Reason for completion: <input type="radio"/> Delete Employee (section 1) <input type="radio"/> Beneficiary Change (sections 1 & B) <input type="radio"/> Address Change (section 1) <input type="radio"/> Add Dependent (sections 1 & A) <input type="radio"/> Birth Date Correction (sections 1 & C) <input type="radio"/> Delete Dependent (sections 1 & A) <input type="radio"/> Name Change (sections 1 & D)	Insurance company/carrier name: Policy/contract number(s):
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1 GROUP AND EMPLOYEE INFORMATION (MUST BE COMPLETED FOR ALL CHANGES)

Group name and division name/number	Employee ID number(s)	Effective date of change (dd/mm/yy)	
Employee name (Last/First/Middle)	Sex <input type="radio"/> M <input type="radio"/> F	Birth date (dd/mm/yy)	
Current/New mailing address	City	Province	Postal code

A CHANGE OF COVERAGE DUE TO CHANGE IN FAMILY STATUS

Required health coverage <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Waived*	Required dental coverage <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Waived*	Do you require Dependent Life insurance? <input type="radio"/> Yes <input type="radio"/> No	
Spouse/Child name (Last/First/Middle) <small>Spouse</small>	Birth date (dd/mm/yy)	Sex <input type="radio"/> M <input type="radio"/> F	Full-time student? N/A
Child		<input type="radio"/> M <input type="radio"/> F	Disabled dependent? N/A
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No
Child		<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> Yes <input type="radio"/> No

* If you are waiving health and dental coverage because you have comparable spousal coverage, you must complete a Waiver Form.

B BENEFICIARY CHANGE – I designate as revocable beneficiary in the event of my death

To which benefit does this change apply? <input type="radio"/> Basic Life Insurance <input type="radio"/> Basic AD&D Insurance <input type="radio"/> Optional Life Insurance <input type="radio"/> Optional AD&D Insurance		
Name of beneficiary (Last/First/Middle)	Share of proceeds %	Relationship to employee

Name of trustee for beneficiaries under age 18
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C BIRTH DATE CORRECTION

Change applicable to <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependent Children	
Spouse/Child name (Last/First/Middle) <small>Spouse</small>	Birth date (dd/mm/yy)
Child	
Child	

D NAME CHANGE

Current name in full (Last/First/Middle)
New name in full (Last/First/Middle)
Change applicable to: <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependent Children

2 EMPLOYEE DECLARATION

I hereby confirm the above changes/modifications and/or beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time.

_____, 20____
Employee signature Date signed