Roman Catholic Archbishop of Vancouver in Association with Canada Life Assurance Company
Policy No. 's. 335645, 335646 & 56565 / Division 10

UPDATING DEPENDENT INFORMATION FOR GROUP BENEFITS PLAN

Instructions: HANDWRITTEN, FORMS WITHOUT THE EFFECTIVE DATE and REASON/TERMINATION WILL NOT BE PROCESSED

1. This form MUST be completed electronically.
2. Complete the section where the update/changes are applicable.
3. The employer must email a clear scanned copy to the Benefits Administration Office and keep the original signed form.

1. a Policyholder Section - To be completed by EMPLOYER

THE EFFECTIVE DATE OF CHANGE MUST BE PROVIDED Month: _____ Day: _____ Year: _____

EMPLOYER Name: _____ ER#: _____ Benefit Class: _____

Reason for change: _____ Specify: _____

Job Title: _____ ID No.: _____

1. b To be completed by EMPLOYEE

Employee Name: _____ DOB: _____

Address: _____
Unit/Apt No.: Street No.: Street Name: City: Prov: Postal Code:

Home Phone: _____ Mobile Phone: _____

Personal Email: _____ Work Email: _____ Marital Status: _____

2. Updating Dependent Information – to be completed by the Employee.

Spouse's Information: ☐ **Add** ☐ **Revise** ☐ **Remove**

_____ Date of Birth _____ Gender ☐ Male ☐ Female
FIRST Name LAST Name Date of Birth MMM-DD-YYYY

Dependent Children Information: ☐ **Add** ☐ **Revise** ☐ **Remove**

_____ _____ _____ ☐ Male ☐ Female
First Name Last Name Date of Birth MMM-DD-YYYY Gender

_____ _____ _____ ☐ Male ☐ Female
First Name Last Name Date of Birth MMM-DD-YYYY Gender

_____ _____ _____ ☐ Male ☐ Female
First Name Last Name Date of Birth MMM-DD-YYYY Gender

_____ _____ _____ ☐ Male ☐ Female
First Name Last Name Date of Birth MMM-DD-YYYY Gender

_____ _____ _____ ☐ Male ☐ Female
First Name Last Name Date of Birth MMM-DD-YYYY Gender

_____ is 22 years old and studying full-time post-secondary school at: _____

_____ is 23 years old and studying full-time post-secondary school at: _____

_____ is 24 years old and studying full-time post-secondary school at: _____

3. Authorization and Declaration: I will apply for coverage under the group benefits plan issued by Canada Life (CL).

I authorize:

- My employer to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable.
- I am responsible for paying back any overpayment made on my Group Benefits and Pension, if applicable.
- CL to use my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Canada Life, my employer's Benefits Representative, and the Benefits Administration Office to exchange personal information when necessary to determine my eligibility for coverage and administer the plan to other insurance/reinsurance companies, administrators of government benefits or other benefits programs, or service providers working with Canada Life.

If applying for coverage for my spouse and dependents: I confirm that I can act on their behalf. I agree that a photocopy or electronic copy of this **Authorizations and Declarations** section is as valid as the original. I certify that the information given is accurate, correct and complete to the best of my knowledge.

EmployEE Signature: _____ Date: _____

EmployER Signature: _____ Date: _____

Signed Form Received by CISVA – Benefits Administration Office: _____