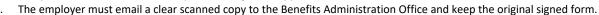
Roman Catholic Archbishop of Vancouver in Association with Canada Life Assurance Company Policy No. 's. 335645, 335646 & 56565 / Division 10

## 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.

Signed Form Received by CISVA – Benefits Administration Office:





1. a Policyholder Section - To be con	mpleted by EMPLOYER	
THE EFFECTIVE DATE OF CHANGE M	IUST BE PROVIDED Month:	Day: Year:
EMPLOYER Name:		ER#:Benefit Class:
Reason for change:		
Joh Titlo		ID No.:
1. b To be completed by EMPLOYEE		
Employee Name:		DOB:
Unit/Apt No.: Street No.: Address:	Street Name: City:	Prov: Postal Code:
Home Phone:	Mobile Phone	:
Personal Email:	Work Email:	Marital Status:
	WOIN LINAII.	iviai itai Status.
2. Updating Dependent Information	<b>n</b> – 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  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
·		
	and studying full-time post-secondary school at:	50 L 1 1 2 L 15 (21)
	will apply for coverage under the group b	enefits plan issued by Canada Life (CL).
I authorize:		
	pay and remit to Canada Life the plan member con any overpayment made on my Group Benefits and	
		ation 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		
, -	/erage and administer the plan to other insurance/ ms, or service providers working with Canada Life.	reinsurance companies, administrators of government
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: