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

GROUP COVERAGE CHANGE FORM

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(MMM-DD-YYYY): _____

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

Address: _____

Home Phone: _____ Mobile Phone:_____

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

Note: MUST be reported as if the Employee had the salary update from September 1st. Complete this section if there are any changes.

Annual Salary: _____ Hours/week: _____ Days/week: _____ Weeks PAID/Year: _____

LEAVING or RETURNING: Termination, reinstated employment, maternity/parental leave, approved LOA, or disability

Income earned/paid within the calendar month of change: $ _____

(this applies to those whose pension contribution needs to be adjusted to accurately reflect earned income for the calendar month that they are actively at work.) If the notice is not provided within seven calendar days, CL may inadvertently overpay the terminated Employee - in this case; the EMPLOYEE will be financially responsible for the overpayment if the Employee does not reimburse CL.

2. Transfer of Employment (i.e., from one school to another) - To be completed by Benefit Representative.

From: _____ To:_____

3. Employee Surname Change - To be completed by Employee.

From:_____To:_____Reason for change: ☐ Marriage ☐ Other Specify: _____

4. Addition of Group Extended Health or Dental Benefits - To be completed by Employee. You may apply to be enrolled for group coverage within 31 days if your spouse has lost group benefits coverage through his/her employer.

The effective date of loss of coverage through the spousal plan MMM-DD-YYYY: _____

Indicate the benefit(s) no longer covered under the spousal plan:

☐ Extended Health (EHB) ☐ Dental ☐ Late Applicant ☐ Back to work from LOA

5. Refusal of Benefits - To be completed by Employee. I understand the plan of group benefits offered to me but decline to participate in: (Employee MUST complete this section if they want to waive the extended health or dental. The spouse's plan MUST be provided. If the information is NOT provided, the Extended Health and Dental coverage will NOT be waived.)

Waive extended health coverage for: ☐ myself and my dependents ☐ my dependents only (Single Coverage)

Waive dental coverage for: ☐ myself and my dependents ☐ my dependents only (Single Coverage)

Insurance Carrier: _____ Policy Number(s): _____

6. Benefits During LOA - To be completed by Employee. I understand the plan of group benefits offered to me. I decide to have the following benefits arrangement during LOA : (Employee MUST complete this section.)

Maternity / Parental LOA :

☐ Continue with all benefits

☐ Opting out all benefits

☐ Continue with all benefits and opting out disability benefits

Other Types of LOA:

☐ Not eligible for all benefits and continue with Extended Health & Dental

☐ Not eligible for all benefits and opting out Extended Health & Dental

7. Pension - To be completed by eligible Benefit Class 1, 2, 4 & 100 EE's only

7.❶ As per the Effective Date of Change, I choose to change my employer-matched contribution to: _____%

(The ER does not match voluntary pension, RRSP, and TFSA contributions). The Employee must provide a dollar amount for the **monthly** contribution.

Voluntary Pension contribution: $ _____ Voluntary RRSP contribution: $ _____ Voluntary TFSA contribution: $ _____

7.❷ Waiver or Reinstatement of RPP Contributions: while on a Maternity/Parental Leave, the Employee may suspend their RPP contributions during the period of their approved leave per Applicable Legislation. An employee on approved LOA or disability cannot contribute to the matched pension plan. While on disability or LOA, the matched pension contribution is suspended. The contribution must be reinstated at the end of the approved leave/return to work from disability.

Effective Date of Change

☐ Temporarily suspend my RPP contribution during my Maternity/Parental Leave/Leave of Absence/Disability

☐ Reinstate my RPP contribution, at the eligible level indicated above in section 7.❶

8. LIFE Beneficiary Designation – For the Employees who are eligible for Life Insurance and those who have been approved for Optional Life

A beneficiary must be designated for your **Group Life Insurance benefit**, if applicable. All primary and contingent beneficiaries listed are Revocable. The plan member can change the Revocable beneficiary(s) at any time.

First Name	Last Name	Relationship	Date of Birth	Gender	Distribution
_____	_____	_____	_____	☐ Male ☐ Female	_____
_____	_____	_____	_____	☐ Male ☐ Female	_____
_____	_____	_____	_____	☐ Male ☐ Female	_____
_____	_____	_____	_____	☐ Male ☐ Female	_____
					Total 100%

Life Contingent beneficiary(ies) – if all listed beneficiaries died before me, the Life benefit set out in the group policy is to be paid to:

First Name	Last Name	Relationship	Date of Birth	Gender	Distribution
_____	_____	_____	_____	☐ Male ☐ Female	_____
_____	_____	_____	_____	☐ Male ☐ Female	_____
_____	_____	_____	_____	☐ Male ☐ Female	_____
_____	_____	_____	_____	☐ Male ☐ Female	_____
					Total 100%

Life Trustee Appointment – Must be appointed if any primary or contingent beneficiaries are minor or otherwise lack legal capacity to receive the proceeds.

Full Name of Trustee (First Name, Last Name)	Trustee for (indicate the name of beneficiary)	Relationship to plan member

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

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

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

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

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

_____ 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: _____

10. 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 Benefits Administration Office: _____