

# Group Benefits ~~±~~e-Application for Change

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

<b>1 General information</b>  We require this information to process your request.   To be completed and signed by plan sponsor.	Plan contract number(s) <b>83713</b>	Plan member certificate number	Plan sponsor <b>Okanagan College</b>
	Plan administrator name		Plan administrator telephone number <b>(250) 762-5445</b> Ext.
	Plan member name (last, first, middle initial)		
I <u>certify</u> that the plan member listed above is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.			
Plan administrator signature		Date signed (dd/mmm/yyyy)	
<b>2 Plan member name change</b>	New name (last, first, middle initial)		
<b>3 Plan member address</b>	Address (number, street, apt. number)		
	City	Province	Postal code
<b>4 Addition of benefits</b>  A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.   *Please enter the date that the common-law cohabitation began in the "Date commenced" field.	<b>Addition of Extended Health Care</b> I wish to ADD Extended Health Care for <input type="radio"/> Myself ONLY <input type="radio"/> Myself AND 1 dependant <input type="radio"/> Myself and 2 or more dependants <input type="radio"/> My dependants ONLY (I am already covered)		<b>Addition of Dental Care</b> I wish to ADD Dental Care for <input type="radio"/> Myself ONLY <input type="radio"/> Myself AND 1 dependant <input type="radio"/> Myself and 2 or more dependants <input type="radio"/> My dependants ONLY (I am already covered)
	<input type="radio"/> Marriage Date of marriage (dd/mmm/yyyy)		<input type="radio"/> <input type="radio"/> <input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 Termination of dependent coverage

<input type="checkbox"/>		
<input type="checkbox"/>		<input type="checkbox"/>

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1 Plan member signature

Please sign and date here.