

Request for change (I)

Plan administrator statement

I Administrative information <i>(please print)</i>			
Policyholder name	Associated Gospel Churches	Policy no.	32102
		Division no.	Certificate no.
Participant surname	Given name(s)	Initial	Date of birth (YYYY/MM/DD)

Participant statement

II Changes requested	
I wish <input checked="" type="checkbox"/> <ul style="list-style-type: none"> <input type="checkbox"/> to cover my dependents (please complete sections III, IV and V) <input type="checkbox"/> to add a dependent, cancel a dependent or correct dependent information (please complete section IV) <input type="checkbox"/> to request individual coverage (please complete section III) <input type="checkbox"/> to advise of a change in my spouse's group insurance plan (please complete section V) <input type="checkbox"/> to cancel or reinstate health care and/or dental care benefits (please complete sections V and VI) <input type="checkbox"/> to change my beneficiary designation (please complete section VII and section VIII and IX, if applicable) <input type="checkbox"/> to advise of a change of name (please complete section X) 	
III Change of coverage	
<input type="checkbox"/> Individual coverage <i>(only the participant is covered)</i> <input type="checkbox"/> Family coverage <i>(the participant and his/her eligible dependents are covered)</i>	
Specify reason for requesting dependent coverage, adding a dependent or terminating spouse's insurance coverage.	
<input type="checkbox"/> Marriage Date of marriage (YYYY/MM/DD)	<input type="checkbox"/> Cohabitation Start date of cohabitation period (YYYY/MM/DD)
<input type="checkbox"/> Birth of 1 st child Child's date of birth (YYYY/MM/DD)	
<input type="checkbox"/> Termination of coverage provided under spouse's group insurance plan	
<input type="checkbox"/> Health care <input type="checkbox"/> Dental care	
Reason for termination:	Date of termination (YYYY/MM/DD)
<input type="checkbox"/> Other (specify):	
Participant signature	Date (YYYY/MM/DD)

IV Information on your dependent(s)												
Specify <input checked="" type="checkbox"/> Addition <input type="checkbox"/> Cancellation <input type="checkbox"/> Correction												
	Surname	Given name(s)	Gender	Date of birth	Are your spouse and/or your dependent children covered under another group insurance plan? ¹				Full-time student ²	Total and permanent disability ³	Dependent children of	
					Health care		Dental care				spouse	participant
			M F	(YYYY/MM/DD)	Yes	No	Yes	No				
Spouse			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
Child			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			

¹ If your spouse and/or dependent children are covered under another group insurance plan, please complete section V.
² If you have dependent children who have reached the first age limit stipulated in the contract, please complete Confirmation of school attendance form G2229 and submit it with this form.
³ If you have disabled dependent children who have reached the first age limit stipulated in the contract, please complete the Application for total and permanent disability status for a dependent child form PC GE10352 and attach it to this Application. This form can be obtained by calling us at 1-800-499-4415.

V Information about your spouse's group insurance plan			
Name of your spouse's group insurer	Policy no.	Coverage:	Health care <input type="checkbox"/> Individual <input type="checkbox"/> Family Dental care <input type="checkbox"/> Individual <input type="checkbox"/> Family

VI Exemption request for benefits covered under your spouse's group insurance plan

Cancellation of benefit(s) (please also complete Section V)

I decline health care benefits¹: for myself and my dependents for my dependents only
 I decline dental care benefits: for myself and my dependents for my dependents only

¹ Pursuant to An Act respecting prescription drug insurance, Québec residents must provide medical coverage for themselves and their dependents unless this coverage is provided under the spouse's group insurance plan or any recognized group insurance plan.

Start date of coverage provided under my spouse's group insurance plan Date (YYYY/MM/DD)

Participant signature Date (YYYY/MM/DD)

Reinstatement of benefit(s) (please also complete Section V)

I am no longer covered under my spouse's group insurance plan. I hereby request reinstatement of:

Health care benefits¹: for myself only for myself and my dependents
 Dental care benefits: for myself only for myself and my dependents

¹ Pursuant to An Act respecting prescription drug insurance, Québec residents must provide medical coverage for themselves and their dependents unless this coverage is provided under the spouse's group insurance plan or any recognized group insurance plan.

Date of termination of coverage for health and/or dental care benefits under my spouse's group insurance plan: Date (YYYY/MM/DD)

Reason for termination:

Participant signature Date (YYYY/MM/DD)

VII Change of beneficiary designation

This beneficiary designation applies to all life insurance benefits under the policy.

Beneficiary surname	Given name	Relationship to participant	%

If the designated beneficiary is legal heirs or estate, please write in full "Legal heirs" or "Estate" and do not provide name(s), given name(s) or relationship to participant. If you wish to designate a contingent beneficiary, please complete the Beneficiary designation form GE9874. If more than one beneficiary is designated and if one of the beneficiaries dies before the participant, his/her share will be divided equally among the other designated beneficiaries.

In accordance with the terms and conditions of the above-mentioned group insurance policy, I, the undersigned, hereby revoke any previous designation of beneficiary and name the above-mentioned person as my beneficiary entitled to receive any amount payable under this policy upon my death. If this beneficiary predeceases me and I do not have a contingent beneficiary, the death benefit will be payable to my estate.

Participant signature Date (YYYY/MM/DD)

VIII Québec participants (to be completed if beneficiary is your spouse – marriage or civil union)

In Québec, the designation of a spouse, excluding common-law spouse, as beneficiary is irrevocable unless otherwise specified. If you designate your spouse as beneficiary, Standard Life recommends that you make a revocable designation in order to facilitate any future request for a change of beneficiary. An irrevocable designation cannot be changed unless the beneficiary, aged 18 or over, signs a waiver of rights.

Please sign in the box corresponding to your choice ONLY IF you designate your SPOUSE as beneficiary.

This beneficiary designation is **revocable**

This beneficiary designation is **irrevocable**

Or

Participant signature

Participant signature

IX Declaration appointing Trustee (to be completed if beneficiary is under legal age)

I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under legal age and I declare that the receipt of such Trustee shall be valid discharge to Standard Life of the amount so paid. I also hereby authorize such Trustee at his/her discretion to apply on behalf of such beneficiary the whole or any portion of such amount and the income derived therefrom for the care, maintenance, education, advancement in life or other benefit of such beneficiary.

Participant signature Date (YYYY/MM/DD)

X Name change

New surname New given name(s) Initial

Reason for change Marriage Correction Other (specify) :

Participant signature Date (YYYY/MM/DD)