

# CHANGE OF RECORD

Please print in ink and sign.

## 1. BASIC INFORMATION

Policyholder's name (Employer/organization) \_\_\_\_\_ Group policy no. [ ] [ ] [ ] [ ] [ ] [ ]  
Division no. [ ] [ ] [ ] [ ] Class no. [ ] [ ] [ ] [ ] Location \_\_\_\_\_ Certificate no. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
Member's name (as shown on our records) \_\_\_\_\_  
Authorized signature (administrator) \_\_\_\_\_ Date \_\_\_\_\_

## 2. CHANGE OF NAME OR ADDRESS

Last name \_\_\_\_\_ First name \_\_\_\_\_  
Reason:  Correction  Marriage/Civil union – Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Moved  Divorced/Separated – Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
Address \_\_\_\_\_ Postal code [ ] [ ] [ ] [ ] [ ] [ ]  
No. Street City Province  
Email: \_\_\_\_\_ Effective date of change of address: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

## 3. CHANGE OF STATUS (Please specify the details in the dependents section)

I wish to change my status to:  Individual  Family  Other: \_\_\_\_\_

Reason:  
 Marriage/Civil Union – Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Birth – Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Common-law – Spouse Cohabitation began on: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Divorced/Separated – Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Coverage under spouse's plan terminated – Termination date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Other \_\_\_\_\_ Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Dependents:	Last name	First name	Sex	Date of birth		
<input type="checkbox"/> Add spouse			<input type="checkbox"/> M	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]		
<input type="checkbox"/> Delete spouse			<input type="checkbox"/> F	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]		
<input type="checkbox"/> Add child			<input type="checkbox"/> M	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	Full-time student	Handicapped
<input type="checkbox"/> Delete child			<input type="checkbox"/> F	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add child			<input type="checkbox"/> M	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	Full-time student	Handicapped
<input type="checkbox"/> Delete child			<input type="checkbox"/> F	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your spouse is insured for Health and Dental Benefits, please complete the sections entitled "COORDINATION OF BENEFITS AND WAIVER OF BENEFITS".  
If you wish to apply for Optional Life Insurance on your spouse (if available), please complete the section entitled "ADD OPTIONAL BENEFITS".

## 4. STATEMENT FOR DEPENDENTS OVER AGE 21

Last name \_\_\_\_\_ First name \_\_\_\_\_ Sex  M  F Date of birth [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
If a full-time student, give name of educational institution: \_\_\_\_\_  
Period: From: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] to [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
If handicapped, nature of handicap: \_\_\_\_\_ Date handicap began [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Last name \_\_\_\_\_ First name \_\_\_\_\_ Sex  M  F Date of birth [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
If a full-time student, give name of educational institution: \_\_\_\_\_  
Period: From: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] to [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
If handicapped, nature of handicap: \_\_\_\_\_ Date handicap began [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

## 5. WAIVER OF BENEFITS (Available only if you have coverage elsewhere)

I WAIVE HEALTH BENEFITS:  for myself and my dependents  for my dependents only  
I WAIVE DENTAL BENEFITS:  for myself and my dependents  for my dependents only  
If checked, please complete Section 7.

## 6. COORDINATION OF BENEFITS (Completion of this section is mandatory for plans that include health and/or dental coverage.)

My spouse does not have health and/or dental coverage (Disregard section 7)  
 My spouse has the following benefits  
Health:  Individual  Family  Waived Dental:  Individual  Family  Waived  
If checked, please complete Section 7.

## 7. MANDATORY INFORMATION ON SPOUSE'S INSURANCE (If applicable)

Spouse's name \_\_\_\_\_ Spouse's group policy no. \_\_\_\_\_ Spouse's certificate no. \_\_\_\_\_  
Spouse's date of birth [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
Spouse's insurance company \_\_\_\_\_ Spouse's employer \_\_\_\_\_

If you waive coverage and wish to request it at a later date, certain conditions may apply. Please contact your plan administrator for further details.

YOU MUST COMPLETE AND SIGN THE MEMBER'S CONFIRMATION AND AUTHORIZATION ON THE REVERSE SIDE.

**8. ADD OPTIONAL BENEFITS** (Check with your plan administrator if optional benefits are offered in your group insurance contract and if an additional form is required)

	LIFE	AD&D	CRITICAL ILLNESS	STATEMENT
<b>Member</b>	\$ _____	\$ _____	\$ _____	In the last twelve months, have any of the proposed insureds used tobacco in any form whatsoever, including tobacco or nicotine products (gum, patches, etc.)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Member's signature X</b> _____
<b>Spouse</b>	\$ _____	\$ _____	\$ _____	In the last twelve months, have any of the proposed insureds used tobacco in any form whatsoever, including tobacco or nicotine products (gum, patches, etc.)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Spouse's signature X</b> _____
<b>Child</b>	\$ _____	\$ _____	\$ _____	

**9. TERMINATION OF OPTIONAL BENEFITS**

	Optional Life	Accidental Death & Dismemberment	Critical Illness
I wish to terminate the following insurance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish to terminate the following insurance on my spouse:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish to terminate the following insurance on my dependents:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. CHANGE OF BENEFICIARY DESIGNATION** (If no beneficiary is designated by the member then the benefit is payable to the estate)

Last name	First name	Relationship	%	Date of birth	
				Y M D	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
					<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

**In Quebec, if no choice is made, the designation of the legal spouse is irrevocable and any other choice is revocable. The beneficiary designation above applies to the member's insurance. Dependent claims will be payable to the member. If one of the designated beneficiaries dies before the participant, his share will be distributed proportionately with the other beneficiaries. To replace or make changes to a previously designated irrevocable beneficiary, please obtain his/her signature.**

Irrevocable beneficiary's signature \_\_\_\_\_ Date \_\_\_\_\_

**MEMBER CONFIRMATION AND AUTHORIZATION**

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If changing information on my spouse and/or dependent children, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their coverage under my Employer/Policyholder's group plan.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my Employer/Policyholder and Industrial Alliance, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my Employer/Policyholder's group insurance plan.

If my Social Insurance Number is used as my identification number, I AUTHORIZE its use for the administration of my group benefits.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature \_\_\_\_\_ Date \_\_\_\_\_

**DISCLOSURE**

At Industrial Alliance, the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for the purposes you have authorized.

Your personal file will be kept at Industrial Alliance's offices. You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, QC G1K 7M3.

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your Employer/Policyholder statistical financial information without personal identifiers.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance group. This will help us serve them better and determine whether any products and services that the Industrial Alliance group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Information Access Officer, as referred to above.