Group Benefits ±e-Application for Change

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

1 General information

We require this information to process your request.

Plan contract number(s)	Plan member certificate number	Plan sponsor
83713		Okanagan College

Plan administrator name	Plan administrator telephone number
	(250) 762-5445 Ext.

Plan member name (last, first, middle initial)

To be completed and signed by plan sponsor.

I certify 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)

2 Plan member name change

New name (last, first, middle initial)

3 Plan member address

Address (number, street, apt. number)

City	Province	Postal code

4 Addition of benefits

A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.

Addition of Extended Health Care I wish to ADD Extended Health Care for	Addition of Dental Care I wish to ADD Dental Care for
Myself ONLY	◯ Myself ONLY
Myself AND 1 dependant	◯ Myself AND 1 dependant
Myself and 2 or more dependants	◯ Myself and 2 or more dependants
My dependants ONLY (I am already covered)	◯ My dependants ONLY (I am already covered)

◯

Marriage

Date of marriage (dd/mmm/yyyy)

*Please enter the date that the common-law cohabitation began in the "Date commenced" field.

6 Termination of dependent coverage

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1 Plan member signature

Please sign and date here.