CHANGE REQUEST

ACTIVE MEMBERS OF QPAT

Mail: Administration
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Fax: 1-888-780-2376
Email : groupinsurance@ia.ca

TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (Please print in ink)

School Board's name _____ **Group policy no**.: ☐ 97000 ☐ 97001

Division no. _____ Class no.: ☐ Full time 100 ☐ Part-time 200 Certificate no. _____

Badge no.: _____

Participant name (as indicated in our files) _____

Plan administrator's signature _____ Date Y M D

Plan administrator's email _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE PARTICIPANT (Please print in ink)

1. CHANGE OF COVERAGE

I want to change my coverage to: ☐ Individual ☐ Family ☐ Single parent ☐ Couple

Raison :

☐ Marriage/Civil Union – Date Y M D

☐ Common-law spouse[1] – Cohabitation began on Y M D

☐ Divorce/Separation – Date Y M D

☐ Birth/Adoption – Date Y M D

☐ New coverage under spouse's plan
– Began on Y M D

☐ Termination of coverage under spouse's plan
– Terminated on Y M D

☐ Other, specify_____ – Date Y M D

	Last name	First name	Sex	Date of birth (YYYY-MM-DD)	
☐ Add spouse[1] ☐ Remove spouse	Spouse		☐ M ☐ F		Date of marriage : Y M D Or cohabitation since : Y M D
☐ Add child ☐ Remove child	Child		☐ M ☐ F		If age 18 or over, specify ☐ Full-time student ☐ Handicapped
☐ Add child ☐ Remove child	Child		☐ M ☐ F		If age 18 or over, specify ☐ Full-time student ☐ Handicapped

[1]If your spouse is a common-law spouse, the cohabitation period must be minimum one year.

2. APPOINTMENT OR CHANGE OF BENEFICIARY *(If no beneficiary is designated, the benefit is payable to your estate.)*

If you name multiple beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

Last name	First name	Relationship	Date of birth (YYYY-MM-DD)	%

IMPORTANT: For Quebec residents only – to be completed if you appointed your spouse (marriage or civil union) as a beneficiary.

In Quebec, the designation of a spouse, excluding a common-law spouse, as a beneficiary is irrevocable* unless you check the following box: ☐ Revocable beneficiary

* To change the appointment of an irrevocable beneficiary, his/her written consent will be required.

As irrevocable beneficiary, I agree to the change of beneficiary designation. YYYY-MM-DD

Irrevocable beneficiary 's signature _____ Date _____

2. CHANGE OF BENEFITS

	FULL TIME TEACHER	PART-TIME TEACHER
Health Insurance • Participant only • Participant and spouse • Participant and children • Participant, spouse and children	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ Type of protection ❑ Prescription drug only ❑ Full benefit
❑ **Exemption** - I request to be exempted from the health insurance benefit because I am covered as a dependent under my spouse's plan. Spouse's name _____ Insurer _____ Policy no. _____		
Participant's Basic Life Insurance (optional) ❑ None, or choose from 1 to 6 units of $25,000	❑ Add _____units ❑ Remove _____units	❑ Add _____units ❑ Remove _____units
Participant's Additional Life Insurance (optional) ❑ None, or choose from 1 to 4 units of $25,000	❑ Add _____units* ❑ Remove _____units*	❑ Add _____units* ❑ Remove _____units*
Dependent's Life Insurance (optional) • None • Spouse only • Children only • Spouse and children	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑
Long-Term Disability Income Insurance (optional for part-time employees)	❑ Yes ❑ Exemption**	❑ Yes ❑ No

** **Long-Term Disability Income Insurance exemption**

Effective date of the exemption Y M D Reason _____

PLAN MEMBER CONFIRMATION/AUTHORIZATION

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

If providing or 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 insurance 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 Insurance and Financial Services Inc. ("the Company"), its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my depen- dents in my Employer's/Policyholder's group insurance plan.

If any contributions are required to be made by me with respect to my group benefits, **I AUTHORIZE** my employer to make any required deductions from my earnings and remit same to the Company.

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

Member's signature _____ Date YYYY-MM-DD _____

DISCLOSURE

At Industrial Alliance Insurance and Financial Services Inc. ("the Company"), 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 the Company's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, send a written request to: Industrial Alliance Insurance and Financial Services Inc., Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec, G1K 7M3.

Access to your personal information will be limited to employees, agents, reinsurers and service providers of the Company in the performance of their duties, individuals to whom you have granted access, and persons authorized by law. For the purposes of audits and administrative reporting, the Company may release to your Employer/Policyholder statistical financial information without personal identifiers.

NOTE : Send one copy to your School Board and the original to Industrial Alliance. Keep one copy for your files.