THE Great-West Life ASSURANCE COMPANY

GROUP BENEFITS CHANGE FORM

Return this completed form to the City of Ottawa, Payroll, Pensions & Benefits, 5th Floor W, 100 Constellation Drive Ottawa ON K2G 6J8, or through internal mail, to mail code 26-31, email a scanned copy to pensionandbenefitsinquiries@ottawa.ca or fax to 613-580-2598.

Please print clearly and complete both sides of form. If you wish, retain a photocopy for your files.

Should you have any questions regarding this form, contact Payroll, Pensions & Benefits at 613-580-2424, ext. 47411.

***Note:** To update your address or emergency contact, please go to Ozone, click on EmployeeInfo/My Work Items. To record a name or date of birth change, please call 613-580-2424 ext., 47411 to request the **Employee Personal Data Form**.*

SECTION 1 - PERSONAL INFORMATION

Employee Name (Last Name, First Name)	Employee / Member ID #	Date of Birth (yyyy/mm/dd - 1964/06/28)	Gender
			☐ Male ☐ Female

SECTION 2 - REASON FOR BENEFITS COVERAGE CHANGE

Date of Change (yyyy/mm/dd): _____

(✓) Reason for Change

- ☐ Marriage
- ☐ Commencement of Common-Law Relationship
- ☐ Divorce/Separation
- ☐ Addition of a Dependent
- ☐ Death of Spouse/Child
- ☐ Loss of Spousal Coverage
- ☐ Voluntary Reduction in Level of Coverage
- ☐ Voluntary Discontinuation of Coverage
- ☐ Retirement of Spouse Carrying Coverage
- ☐ Re-Establish Over-Age Student Eligibility
- ☐ Coordination of Benefits and Changing First Payer Status
- ☐ Change in Smoking Status
- ☐ Other _____

***Note:** if there is a change needed to your dependent information as a result of the reason checked above, **complete Section 4 on the reverse**.*

SECTION 3 - BENEFITS TO BE CHANGED

(✓) Benefit(s) to Be Changed

- ☐ **Dental Plan** ☐ Single ☐ Family ☐ Opt Out – spouse has coverage, COB not required OR OPL PT only – voluntary discontinuation
- ☐ **Health Plan** ☐ Single ☐ Family ☐ Opt Out – spouse has coverage, COB not required OR OPL PT only – voluntary discontinuation
- ☐ **My coverage level is not changing, but I wish to amend my dependent information** *(complete Section 4 on reverse)*

• **Optional Critical Illness** - for all groups (Para Transpo and IATSE effective May 1, 2017)

☐ **Child(ren)**
- ☐ Adding child coverage $10,000 (non-evidence)
- ☐ Voluntary discontinuation of coverage
- ☐ Transfer coverage from spouse working at the City of Ottawa – spouse's employee #: _____

☐ **Employee**
- ☐ Reduce coverage to: $ _____ (in multiples of $5,000, minimum $10,000)
- ☐ Voluntary discontinuation of coverage
- ☐ Transfer coverage from spouse working at the City of Ottawa – spouse's employee #: _____

☐ **Spouse**
- ☐ Reduce coverage to: $ _____ (in multiples of $5,000, minimum $10,000)
- ☐ Voluntary discontinuation of coverage
- ☐ Transfer coverage from spouse working at the City of Ottawa – spouse's employee #: _____

• **Optional Accidental Death and Dismemberment** - for MPE, CIPP, CUPE 503, IATSE, Library, OPFFA, and Para, if under age 65. For transfer of coverage from spouse working at the City of Ottawa, increase, reduction or voluntary discontinuation of coverage.
For details on coverage and premium cost, contact Payroll, Pensions & Benefits at 613-580-2424, ext. 47411.

☐ **Employee only**
- ☐ Coverage amount: $ _____
- ☐ Voluntary discontinuation of coverage
- ☐ Transfer coverage from spouse working at the City of Ottawa – spouse's employee #: _____

☐ **Employee & Family**
- ☐ Coverage amount: $ _____
- ☐ Voluntary discontinuation of coverage
- ☐ Transfer coverage from spouse working at the City of Ottawa – spouse's employee #: _____

• **Optional Life** - for all groups
For reduction in coverage or voluntary discontinuation of coverage.

☐ **Employee only**
- ☐ Reduce coverage to: $ _____
- ☐ Voluntary discontinuation of coverage

☐ **Spouse**
- ☐ Reduce coverage to: $ _____
- ☐ Voluntary discontinuation of coverage

• **Optional Dependent Life** - only applicable to Para Transpo
- ☐ Option 1 – $10,000 coverage for spouse, $5,000 per child
- ☐ Option 2 – $5,000 coverage for spouse, $2,500 per child
- ☐ Voluntary discontinuation of coverage

***Note:** Enrolment for or increase of Optional Critical Illness and Optional Life (with the exception of an eligible transfer of Optional Critical Illness benefits from your spouse who works at the City of Ottawa) requires application with evidence of insurability where medical questions must be answered. Enrolment in Optional AD&D must be done through an Enrolment Form. In both of these cases, contact Payroll, Pensions & Benefits at the number above.*

Declaration of Smoking Status - Must to be completed if you are changing your smoking status for current Critical Illness and/or Optional Life

For the Employee

I declare that:

☐ I have not smoked or used ☐ I have smoked or used

any cigarettes, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts or tobacco or nicotine in any other form within the last TWELVE months.

Employee Signature: _____

Date (yyyy/mm/dd): _____

For the Spouse

I declare that:

☐ My spouse has not smoked or used ☐ My spouse has smoked or used

any cigarettes, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts or tobacco or nicotine in any other form within the last TWELVE months.

Spouse Signature: _____

Date (yyyy/mm/dd): _____

SECTION 4 - DEPENDENT INFORMATION

Complete this section only if you are changing information pertaining to a dependent that you have previously enrolled **OR** if you are adding or deleting a dependent.

SPOUSAL INFORMATION

Definition of spouse: The person of either sex who is your legal spouse or with whom you have been living in a role like that of a marriage partner continuously for at least 12 months and who is a resident of Canada. Only one spouse is eligible for coverage.

Change Reason A = add C = change D = delete	Last Name	First Name	Date of Birth (yyyy/mm/dd)	Gender (M/F)	Relationship* (common law or legally married)

** If you are in a common-law relationship, please complete the common-law declaration below.*

Declaration of Common-Law Relationship

☐ I declare that I have been living in a common-law relationship for at least the last 12 consecutive months.

Employee Signature: _____ **Date Cohabitation Commenced** (yyyy/mm/dd)**:** _____

DEPENDENT CHILD(REN) INFORMATION

Definition of child: Your or your spouse's unmarried, natural, legally adopted, step or foster children who are residents of Canada and **ARE**

- under age 21 (age 22 for ATU 279 & 1760)
- under age 25, if they are full-time students at an accredited institute of learning and depend on you for support,
  - ♦ studying within Canada for ATU 279 and 1760
  - ♦ studying within or outside Canada for all other employee groups or
- of any age, if mentally or physically disabled and incapable of self-sustaining employment and totally dependent on you for support, provided the disability began before they reached age 21 (age 22 for ATU 279 & 1760) or while they were full-time students under age 25, and the disability has been continuous since then.

Change Reason A = add C = change D = delete	Last Name	First Name	Date of Birth (yyyy/mm/dd)	Gender (M/F)	Relationship A = natural adopted or step B = foster or legal guardianship	For Over-age Student* only complete with name of school student is attending

Declaration of Over-Age Full-Time Student*

- I declare that my child(ren) are over an age as specified in the definition of child above and are eligible for coverage as they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the next school year, the upper limit of the dependent definition age, or until coverage is terminated. I also understand that I must re-establish my child's over-age student eligibility by September 1st of each new school year by completing and returning this form.

Full time student for the following school year(s): ☐ Current year ending Aug. 31
☐ Upcoming year starting September 1 (should not be completed before July 1)

Employee Signature: _____ **Date** (yyyy/mm/dd)**:** _____

Note: *If you are adding a dependent who is* **over-age and is disabled***, you must contact Payroll, Pensions & Benefits at 613-580-2424, ext. 47411 and/or complete the* ***Application for Over-Age Disabled Dependent Coverage*** *form.*

SECTION 5 - CO-ORDINATION OF BENEFITS (complete if you have any changes related to coordination for Dental and/or Health)

Is your spouse on file covered under another plan?	**If yes, indicate your spouse's plan and level of coverage.**	**Are any of your dependent children covered under another plan other than with your spouse on file?**
☐ Yes ☐ No	**Health** ☐ Single ☐ Family **Dental** ☐ Single ☐ Family	☐ Yes ☐ No

If yes, indicate child's name, plan holder's name and relationship (i.e. former spouse, legal guardian, etc.), and type of coverage.

Name of Plan Holder: _____
Child's Name: _____
Relationship: _____
Date of Birth of Plan Holder (yyyy/mm/dd)**:** _____
Type of Coverage: ☐ **Health** ☐ **Dental**
Does this plan holder have ☐ **single (sole) or** ☐ **joint (shared) custody of the children?**

Name of Plan Holder: _____
Child's Name: _____
Relationship: _____
Date of Birth of Plan Holder (yyyy/mm/dd)**:** _____
Type of Coverage: ☐ **Health** ☐ **Dental**
Does this plan holder have ☐ **single (sole) or** ☐ **joint (shared) custody of the children?**

SECTION 6 - PRIVACY

Protecting Your Personal Information

At **The Great-West Life Assurance Company,** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

SECTION 7 - AUTHORIZATIONS AND DECLARATIONS

I hereby apply for coverage under the group benefits plan issued by Great-West Life.

I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information".

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: _____ **Date** (yyyy/mm/dd)**:** _____

Office Use Only	**Effective Date of Change:**	**SAP Entry Date:**
	Marvel Ticket # (if applicable):	**Evidence of Insurability (EOI) Required:** ☐ **Yes** ☐ **No**
	PP&BO initials:	

Clear