PR036/19

Retiree Benefits Change Form

The information requested on this form is being collected pursuant to the Freedom of Information and Protection of Privacy (FOIP) Act, notably Sections 33, 34, 39 and 40, and is restricted to Division personnel responsible for administering Payroll and Benefits.

Surname:	Given:	Initial:	Retiree#:
Reason for Changes:			

Address/Phone CHANGES

Address:	City, Province:
Postal Code:	Telephone:

Dependent Coverage CHANGES

Spouse and dependents		Relationship to Employee	Birthdate YYYY/MM/DD	Student
Name:	☐ Male ☐ Female			☐ Yes ☐ No
Name:	☐ Male ☐ Female			☐ Yes ☐ No
Name:	☐ Male ☐ Female			☐ Yes ☐ No
Name:	☐ Male ☐ Female			☐ Yes ☐ No

Co-ordination of Benefits CHANGES

Applies to Health and/or Dental: ☐ Health Care ☐ Dental Care

Spouse's Employer:

Insurance Company:

Policy #:

Coverage Level: ☐ Single ☐ Couple ☐ Family

Supplementary Health Care CHANGES

SINGLE ☐ $94.00/month COUPLE ☐ $188.00/month FAMILY ☐ $282.00/month

WAIVED ☐ *(attach letter from spouse's employer confirming coverage from spouse's employer)*

Dental Health Care CHANGES

Single ☐ $72.00/month Couple ☐ $144.00/month Family ☐ $216.00/month

WAIVED ☐ *(attach letter from spouse's employer confirming coverage)* Irrevocable Opt Out ☐ *((no opting back in)*

Life Insurance ($25,000) A.D.& D. ($25,000) *Cost per month $2.40*

REVOCABLE BENEFICIARY:

Surname: Given Name: Relationship:

Phone: Address:

I hereby declare that I have read and understood the information contained on this form and that the use of personal information and the information I have provided is correct.

SIGNATURE: _____ Date: _____