BENEFITS BY DESIGN

EMPLOYEE CHANGE REQUEST

Throughout this form, Benefits by Design Inc. is referred to as BBD.

To use this form, you must already be enrolled in and insured under your employer's plan. Please complete this form, sign it, and submit it to your Plan Administrator. If you are making a change to your beneficiaries, please complete the **Beneficiary Designation Form** as well. For a new enrollment, please complete the **Employee Enrollment Form**.

SECTION 1: EMPLOYMENT INFORMATION

Name of Employer

SECTION 2: EMPLOYEE CHANGE REQUEST

Employee Last Name on File	Employee First Name on File
New Last Name	

Reason for Name Change
○ Marriage ○ Divorce/Separation ○ Incorrect Information on file
○ Other (specify): _____

New Home Address

City	Province	Postal Code	Effective Date of Change (mm/dd/yyyy)

REASON FOR CHANGE

○ Marriage — Date of Marriage (mm/dd/yyyy):

○ Common Law Spouse — Date of Cohabitation (mm/dd/yyyy):

○ Birth or Adoption of Child — If adoption, provide date (mm/dd/yyyy):

○ Children of Common Law Spouse *(must reside with you)*
Date dependents acquired (mm/dd/yyyy):

○ Separation/Divorce — Date of separation/divorce (mm/dd/yyyy):
Is former spouse still to be covered?* ○ Yes ○ No
Are children still to be covered?* ○ Yes ○ No
**Complete the reinstatement or partial waiver sections*

○ Death of Dependent
Date of Death (mm/dd/yyyy):_____
Dependent Name:_____
Relationship:_____

○ Other (specify, including date of change):_____

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SECTION 3: DEPENDENT COVERAGE (TO BE COMPLETED BY THE EMPLOYEE)

Relation	Last Name	First Name	Date of Birth (mm/dd/yyyy)	Gender	Children over 21, name of school and/or disability
Spouse ○ Add ○ Remove				○ Male ○ Female ○ Undisclosed	
Child ○ Add ○ Remove				○ Male ○ Female ○ Undisclosed	
Child ○ Add ○ Remove				○ Male ○ Female ○ Undisclosed	
Child ○ Add ○ Remove				○ Male ○ Female ○ Undisclosed	

SECTION 4: PARTIAL WAIVER

By completing this section, I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan.

Insurance Company	Group Number	ID Number

WAIVER OF COVERAGE FOR:

Myself & my dependents:	☐ I waive Extended Health ☐ I waive Dental	My dependents only:	☐ I waive Extended Health ☐ I waive Dental

Is this comparable coverage provided by a spouse's group plan? ○ Yes ○ No

If coverage is not provided by a spouse's group plan, please provide details below.

RAMQ Coverage (for Quebec residents aged 65 or older):

Member: ○ RAMQ ○ Private Coverage ○ Both	Spouse: ○ RAMQ ○ Private Coverage ○ Both

SECTION 5: REINSTATEMENT OF WAIVED BENEFITS

By completing this section, I wish to apply for my employer's Extended Health and/or Dental Care benefits which I previously waived.

Myself & my dependents:	☐ Reinstate Extended Health ☐ Reinstate Dental	My dependents only:	☐ Reinstate Extended Health ☐ Reinstate Dental

REASON FOR APPLICATION

○ Termination of another plan.
Date of termination of plan (mm/dd/yyyy)_____
○ Separation or Divorce.
Date of termination of plan (mm/dd/yyyy)_____
If you have children, are they still covered under another plan? ○ Yes (specify below) ○ No

Insurance Company	Group Number	ID Number

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SECTION 6: DECLARATION & AUTHORIZATION

I ACKNOWLEDGE AND AGREE that the contract(s) between my employer and the insurer(s) and service providers of my benefits coverage requires deductions for contributions from my earnings and **I AUTHORIZE** my employer to make all such deductions.

I AUTHORIZE BBD to collect, use and disclose my personal information and the personal information of my dependents and beneficiaries for my benefits coverage in accordance with BBD's privacy policy in effect from time to time. The most recent version of BBD's Privacy Policy can be found on the website. My continued provision of personal information to BBD or my continued use of BBD's services following any changes to BBD's Privacy Policy constitutes my acceptance of any changes to BBD's Privacy Policy from time to time.

I UNDERSTAND that this original document and all other personal information pertaining to me and my dependents and beneficiaries for my benefits coverage are in the property of BBD and will be retained by BBD in accordance with its record keeping requirements and as required by law, regulatory requirements and BBD's contractual arrangements.

I CONFIRM that the information I have provided in this form is true, correct, and complete.

Signature of the Employee **Date of Signature** (mm/dd/yyyy)

X _____ _____

SECTION 7: DISCLOSURE

At BBD, we are committed to protecting the privacy and the confidentiality of your personal information we collect concerning you and your dependents. Your personal information is stored by BBD in accordance with our Privacy Policy. You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, please contact your Plan Administrator. Access to your personal information will be limited to as set forth in our Privacy Policy.

SECTION 8: FORM SUBMISSION (FOR PLAN ADMINISTRATORS)

As a Plan Administrator, if you use Nomad to update employee information, please retain this form for your records. If you do not use Nomad, submit a copy of this form to your BBD Client Manager by email, or by mail, and retain the original. You can submit a copy of the form:

Online: Nomad Portal

By Mail:

Company located in British Columbia
Benefits by Design (BBD) Inc.
500-2755 Lougheed Highway
Port Coquitlam, BC
V3B 5Y9

Company located in all other provinces
Benefits by Design (BBD) Inc.
107-6 Cataraqui Street
Kingston, ON
K7K 1Z7

PRINT FORM RESET FORM