COUGHLIN
employee benefits specialists

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CHANGE FORM
- DEPENDENT COVERAGE -
- BENEFICIARY DESIGNATION -

*Please complete the **applicable** sections and **sign and date** the reverse side.*
Return the form for processing.

Note: this form can only be used for changes to your existing records. When enrolling for the first time, please complete an **Application for Group Coverage.**

PLAN MEMBER'S INFORMATION

Local Union or Employer: Alberta Sheet Metal Worker's Health & Welfare Plan

Name of Plan Member: _____

Mailing Address: _____ City and Province: _____ Postal Code: _____

Telephone: _____ Email Address: _____

Social Insurance Number: _____ _____ _____ Date of Birth: _____
day / month / year

CHANGE IN RELATIONSHIP STATUS

Add ☐ Remove ☐

Date of Marriage or Common-Law Relationship

_____
day month year

Date of Separation or Divorce or Co-habitation

_____
day month year

Change of Status due to:

☐ Single ☐ Married ☐ Common-Law ☐ Widowed

☐ Separated ☐ Divorced ☐ Cessation of co-habitation

ADDITION / REMOVAL OF DEPENDENT(S)

I wish to add and/or remove the following dependant(s) from my group benefit plan:

Spouse/Partner's Information

_____
last name first name middle initial

_____
date of birth (day/month/year)

Gender
☐ Male ☐ Female

What group benefits coverage does your spouse have through an employer?

Healthcare → Does this include prescription drug coverage?
☐ Single ☐ Family ☐ Waived ☐ None ☐ Yes ☐ No

Dentalcare
☐ Single ☐ Family ☐ Waived ☐ None

Visioncare
☐ Single ☐ Family ☐ Waived ☐ None

In the case of children of a common-law spouse, I certify that these children reside with me and are dependent upon me for support.

Dependent(s) Information (If there are more than four dependants, please attach a separate list.)	**Date of Birth**	**Relationship to Insured**	**Gender**	**Full time Student**	**Disabled Dependent**
last name first name middle initial	(day / month / year)		Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐
last name first name middle initial	(day / month / year)		Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐
last name first name middle initial	(day / month / year)		Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐

GROUP OR EMPLOYER: _____

Plan Member's name: _____ Date: _____

CHANGE IN BENEFICIARY – HEALTH AND WELFARE PLAN

I hereby revoke all previous beneficiary designations and appoint the following revocable beneficiary(ies) of any Life benefits payable under the Health and Welfare Plan upon my death, and discharge the Trustees of the Plan to the extent of such payment. (Note: Your designation of a beneficiary will not be revoked or changed automatically by any future marriage or divorce. Should you wish to change your beneficiary in the event of a future marriage or divorce, you will have to do so by means of a new designation.) **If more than one beneficiary is named, total distribution of the benefits must equal 100%.**

Beneficiary's Name(s)			Percent allocated	Relationship to Plan Member
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

Contingent beneficiary – or Secondary beneficiary in the event the beneficiary(ies) dies before me, the life benefit set out in the Group Insurance plan is to be paid to:

Name of contingent beneficiary _____ Relationship to Plan Member _____

Signature of Plan Member: _____ Date: _____
D / M / Y

PLEASE RETURN TO COUGHLIN & ASSOCIATES LTD.