

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

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

Participants do not complete this section. TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR

School board's name: English Montreal School Board _____ **Group policy no:** 97001

Division no. 887 _____ Class no.: Full-time 100 Part-time 200

Badge no. _____

Plan administrator's signature **X** _____ Date

Y	M	D

Plan administrator's email: eioannidis@emsb.qc.ca _____ Tel no. _____

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

Plan member's name (as indicated in our records) _____ Certificate no. _____

1. CHANGE OF COVERAGE

I want to change my coverage to: Individual Family Single parent Couple **IMPORTANT:** You must check a *level of coverage*, the *event/reason* that applies and fill in the *date* of the event. Note: You must file **within 30 days** of a life event.

Event/Reason and Date that applies: If you already have a family plan and you are *only adding a dependant*, you do not have to complete this form. Call IA customer service.

Marriage/Civil Union – Date

Y	M	D

 New coverage under spouse's plan

Common-law spouse¹ – Cohabitation began on

Y	M	D

 – Began on

Y	M	D

Divorce/Separation – Date

Y	M	D

 Termination of coverage under spouse's plan

Birth/Adoption – Date

Y	M	D

 – Terminated on

Y	M	D

If none of the above apply Other (specify) _____ Date

Y	M	D

	Last name	First name	Sex	Date of birth	Date of marriage: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>M</td><td>D</td></tr><tr><td> </td><td> </td><td> </td></tr></table> OR cohabitation since: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>M</td><td>D</td></tr><tr><td> </td><td> </td><td> </td></tr></table>	Y	M	D				Y	M	D			
Y	M	D															
Y	M	D															
<input type="checkbox"/> Add spouse ¹ <input type="checkbox"/> Remove spouse	Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>M</td><td>D</td></tr><tr><td> </td><td> </td><td> </td></tr></table>	Y	M	D										
Y	M	D															
<input type="checkbox"/> Add child <input type="checkbox"/> Remove child	Child		<input type="checkbox"/> M <input type="checkbox"/> F	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>M</td><td>D</td></tr><tr><td> </td><td> </td><td> </td></tr></table>	Y	M	D				If age 18 or over, specify <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled						
Y	M	D															
<input type="checkbox"/> Add child <input type="checkbox"/> Remove child	Child		<input type="checkbox"/> M <input type="checkbox"/> F	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>M</td><td>D</td></tr><tr><td> </td><td> </td><td> </td></tr></table>	Y	M	D				If age 18 or over, specify <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled						
Y	M	D															

¹ If your spouse is a common-law spouse, the cohabitation period must be a minimum of 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	%						
			<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>M</td><td>D</td></tr><tr><td> </td><td> </td><td> </td></tr></table>	Y	M	D				
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Y	M	D								

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.

Irrevocable beneficiary's signature **X** _____ Date

Y	M	D

3. CHANGE OF BENEFITS

	FULL-TIME TEACHER	PART-TIME TEACHER
Health Insurance <ul style="list-style-type: none"> • Plan member only • Plan member and spouse • Plan member and children • Plan member, spouse and children 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <p>Type of protection for dependents</p> <input type="checkbox"/> Prescription drug only <input type="checkbox"/> Full benefits
<input type="checkbox"/> 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 <input type="text"/> Insurer <input type="text"/> Policy no. <input type="text"/>		
Plan member’s Basic Life Insurance (optional) <input type="checkbox"/> None, or choose from one to six units of \$25,000	<input type="checkbox"/> Add _____ units <input type="checkbox"/> Remove _____ units	<input type="checkbox"/> Add _____ units <input type="checkbox"/> Remove _____ units
Plan member’s Additional Life Insurance (optional) <input type="checkbox"/> None, or choose from one to four units of \$25,000 <small>*Note -You need to select six units of basic life insurance to be eligible for additional life insurance.</small>	<input type="checkbox"/> Add _____ units* <input type="checkbox"/> Remove _____ units	<input type="checkbox"/> Add _____ units* <input type="checkbox"/> Remove _____ units
Dependent’s Life Insurance (optional) <ul style="list-style-type: none"> • None • Spouse only • Children only • Spouse and children 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Long-Term Disability Income Insurance (optional for part-time employees)	<input type="checkbox"/> Add <input type="checkbox"/> Exemption**	<input type="checkbox"/> Yes <input type="checkbox"/> No
** Long-Term Disability Income Insurance exemption (full-time only) Effective date of the exemption <input type="text"/> Y <input type="text"/> M <input type="text"/> D Reason <input type="text"/>		

PLAN MEMBER CONFIRMATION AND 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 dependents 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.

Plan member’s signature _____ Date Y M D

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 Insurance and Financial Services Inc. Keep one copy for your files.