iA Financial Group

CHANGE REQUEST
ACTIVE MEMBERS OF QPAT

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

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

Employer Portion: Participants *do not* complete this section. TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (HR).

School board's name: English Montreal School Board **Group policy no:** 97001 **Division no.** 887

Class no.: ☐ Full-time 100 ☐ Part-time 200

Employee no. _____

This section is reserved for Human Resources.

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/PARTICIPANT. (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**

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.

VERY 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. * Please attach an explanatory note if necessary.

Event/Reason and Date:

☐ Marriage/Civil Union – Date Y M D

☐ Common-law spouse[1] – Cohabitation began on Y M D

☐ Divorce/Separation – Date Y M D

☐ Birth/Adoption – Date Y M D

☐ **Exemption**/New coverage under spouse's plan – Began on Y M D

☐ Termination of coverage under spouse's plan – 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	
☐ Add spouse[1] ☐ Remove spouse	Spouse		☐ M ☐ F	Y M D	Date of marriage: Y M D OR cohabitation since: Y M D
☐ Add child ☐ Remove child	Child		☐ M ☐ F	Y M D	If age 18 or over, specify ☐ Full-time student ☐ Disabled
☐ Add child ☐ Remove child	Child		☐ M ☐ F	Y M D	If age 18 or over, specify ☐ Full-time student ☐ Disabled

[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	%
			Y M D	
			Y M D	
			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

*Note: Only **permanent** contract teachers are considered FT.*	FULL-TIME TEACHER	PART-TIME TEACHER
Health Insurance • Plan member only • Plan membert and spouse • Plan member and children • Plan member, spouse and children	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ **Type of protection for dependents** ☐ Prescription drug only ☐ Full benefits
☐ **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 _____ Insurer _____ Policy no. _____		
Plan member's Basic Life Insurance (optional) ☐ None, or choose from one to six units of $25,000	☐ Add _____ units ☐ Remove _____ units	☐ Add _____ units ☐ Remove _____ units
Plan member's Additional Life Insurance (optional) ☐ None, or choose from one to four units of $25,000 *Note -You need to select six units of basic life insurance to be eligible for additional life insurance.	☐ Add _____ units* ☐ Remove _____ units	☐ Add _____ units* ☐ Remove _____ units
Dependent's Life Insurance (optional) • None • Spouse only • Children only • Spouse and children	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Long-Term Disability Income Insurance (optional for part-time employees)	☐ Add ☐ Exemption**	☐ Yes ☐ No
**** Long-Term Disability Income Insurance exemption (full-time only)** Effective date of the exemption Y M D Reason _____		

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 converage 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 the original to Human Resources, Group Insurance. Keep a copy for your files.

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