HEALTH CARE PROVIDERS GROUP INSURANCE PLAN ™
CHANGE FORM

C1

ID OR CERTIFICATE #: ______________________________

Last Name: ______________________ **First Name:** ____________________ Initial ______

______________________ / ______________________ /________ / ____________
Home Mailing Address City Province Postal Code

DOB (dd/mm/yyyy): __________ Tel: (H) (   ) _____ - __________ (W) (   ) _____ - __________

Email ______________________________

Current Hospital ______________________ Site ______________________

Is any of this contact information new since your original application or since you last updated your records with us? YES ☐ *NO* ☐

REQUEST TO CHANGE COVERAGE LEVELS OR OPTIONS

CHANGE HEALTH PLAN COVERAGE
(Change plan under which coverage is issued. Coverage level, options and additional coverage will remain the same where applicable unless otherwise requested.)

Currently covered under: **PLAN 1** ☐ **PLAN 1A** ☐ **PLAN 2** ☐ **PLAN 65+** ☐

Move to: **PLAN 1** ☐ **PLAN 1A** ☐ **PLAN 2** ☐ **PLAN 65+** ☐

__________ Date of change

REASON: ______________________________

CHANGE DENTAL PLAN COVERAGE: **ADD** ☐ **DELETE** ☐

Basic Dental ☐ Enhanced Dental ☐

__________ Date of change

CHANGE DEPENDENTS COVERED
(check one of each)

From Single ☐ Couple ☐ Family ☐ To Single ☐ Couple ☐ Family ☐

ADD DEPENDENT(S) listed below ______________ Reason __________ Date of change

REMOVE PERSON(S) listed below ______________ Reason __________ Date of change

Relation	First Name	Last Name	Birth date (dd/mm/yyyy)	Sex (M/F)	Full-Time Student (age 21 to 25)
Spouse					
Child					
Child					

REQUEST TO ADD OPTIONAL ADDITIONAL HEALTH CARE COVERAGE
(Premium for this coverage will be added to the next automatic monthly withdrawal)

PLEASE ADD EXCEPTIONAL EXPENSES INSURANCE – EEI (Under age 70, premium is per family) ☐
PLEASE ADD HEALTHCARE INCIDENTAL INSURANCE – HII (Age 70 – 79, premium is per person covered) ☐

SIGNATURE: ______________________________ Date ______________
(Sign here to authorize all changes requested on this page) (dd/mm/yyyy)

Continued over page

CHANGE FORM – CONTINUED

REQUEST TO TERMINATE ALL COVERAGE UNDER HCP

Please terminate all my coverage under the HCP Plan effective (dd/mm/yyyy) ________________________
Reason for termination:

Taking full time position: ☐ Spouse has obtained health benefits: ☐ Other: ☐ (Please give a brief explanation)

____

____

REQUEST FOR INCREASE OR CHANGE TO CORE COVERAGE

☐ **ADD OR INCREASE LIFE INSURANCE ON DEPENDENT(S) listed below**
(Adding or increasing Life Insurance on spouse or dependents requires completed application forms and a complete Beige worksheet all of which are available on our web site)

Relation	First Name	Last Name	Birth date	Sex
Spouse	__________	__________	__________	_____
Child	__________	__________	__________	_____
Child	__________	__________	__________	_____
Child	__________	__________	__________	_____

☐ **ADD OR INCREASE MY LONG TERM DISABILITY INSURANCE OR MY LIFE INSURANCE**
(Adding or increasing LTD or Life Insurance on the employee's life requires a completed Form 3 and a completed Beige worksheet both of which are available on our web site)

☐ **ADD OR CHANGE BENEFICIARY:** Add Beneficiary ☐ Change Beneficiary ☐
Using this form to designate or change a beneficiary revokes only those designations for the coverage checked by you below

Basic Life/ADD&D ☐ Optional Life ☐ Optional ADD&D ☐

I ____ hereby revoke all previous beneficiary designations for the coverage

checked above and declare that all benefits payable under the Policy after my death for the coverage checked, shall be paid to the following:

BENEFICIARY: ____ Related to me as: ________________________

TRUSTEE: ____ Related to me as: ________________________
(If beneficiary is less than 18 years of age)

SIGNATURE: ____ Date ____________________
(Sign here to authorize all changes requested on this page) (dd/mm/yyyy)

NOTES:

1. If you are applying for additional coverage due to a loss of spousal benefits please include documentary evidence confirming the date you lost your benefits under a spousal group plan (this might be a letter from the HR department where your spouse works, or worked, a copy of the Record of Employment or a formal separation agreement)
2. If you are applying for Enhanced Health Benefits, please include a completed Statement of Health (Form 2).
3. If you are applying for Health Benefits outside an open enrolment window, please include a completed Statement of Health (Form 2) available on our web site or by calling us.
4. If you are applying for Life Insurance or Disability Benefits (other than Plan 1A) and you are applying outside an open enrolment window please include a completed Co-operators Employee Group Health Form (Form 3).
5. If you are using this change form to terminate your coverage please ensure that you have signed your name, inserted the date on which you signed and the effective date of termination. Note that LTD terminations are effective at the end of the last day of your employment and in general all other coverage under HCP begins and terminates at the beginning of a calendar month. HCP must receive the signed termination notice by regular post or fax before the termination will take effect.
6. For Quebec residents – the beneficiary designation is 'irrevocable' unless 'revocable' is written after the beneficiary name.
7. In the event all beneficiaries predecease the employee, benefits shall be paid to the employee's estate. If you are the surviving spouse of an employee who has died and you wish the plan to be registered in your name please include a copy of the death certificate or other suitable evidence.
8. If you are the surviving spouse of an employee who has died and you wish the plan to be registered in your name please include a copy of the death certificate or other suitable evidence.