

# Group Benefits ~~±~~e-Application for Change

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

<p><b>1 General information</b></p> <p>We require this information to process your request.</p>  <p>To be completed and signed by plan sponsor.</p>	<p>Plan contract number(s) <b>83713</b></p>	<p>Plan member certificate number</p>	<p>Plan sponsor <b>Okanagan College</b></p>
	<p>Plan administrator name</p>		<p>Plan administrator telephone number <b>(250) 762-5445</b> Ext.</p>
	<p>Plan member name (last, first, middle initial)</p>		
	<p>I <u>certify</u> that the plan member listed above is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.</p>		
	<p>Plan administrator signature</p>		<p>Date signed (dd/mmm/yyyy)</p>
<p><b>2 Plan member name change</b></p>	<p>New name (last, first, middle initial)</p>		
<p><b>3 Plan member address</b></p>	<p>Address (number, street, apt. number)</p>		
	<p>City</p>	<p>Province</p>	<p>Postal code</p>
<p><b>4 Addition of benefits</b></p> <p>A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.</p>  <p>*Please enter the date that the common-law cohabitation began in the "Date commenced" field.</p>	<p><b>Addition of Extended Health Care</b> I wish to ADD Extended Health Care for</p> <p><input type="radio"/> Myself ONLY</p> <p><input type="radio"/> Myself AND 1 dependant</p> <p><input type="radio"/> Myself and 2 or more dependants</p> <p><input type="radio"/> My dependants ONLY (I am already covered)</p>		<p><b>Addition of Dental Care</b> I wish to ADD Dental Care for</p> <p><input type="radio"/> Myself ONLY</p> <p><input type="radio"/> Myself AND 1 dependant</p> <p><input type="radio"/> Myself and 2 or more dependants</p> <p><input type="radio"/> My dependants ONLY (I am already covered)</p>
	<p><input type="radio"/> _____</p>		
	<p><b>Marriage</b></p>		
	<p>Date of marriage (dd/mmm/yyyy)</p>		
	<p><input type="radio"/> _____</p>		
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6 Termination of dependent coverage

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1 Plan member signature

Please sign and date here.