nova scotia health authority

Group Insurance Coverage Change Form

(NSGEU, Confidential Excluded, Management)

Effective Date of Coverage Change (to be entered by administrator)

Complete all applicable sections. The form must be signed and dated in the presence of a witness on the next page.

Last Name	First Name, Intital(s)	Employee ID	Social Insurance Number

Reason for Change, e.g. marriage, common-law, divorce, widow(er), etc.: _____

Marriage - date of marriage (yyyy/mm/dd)	Common-law - date of cohabitation (yyyy/mm/dd)	Legal separation - date of separation (yyyy/mm/dd)	Divorced - date of divorce (yyyy/mm/dd)	Widow(er) - Date of spouse's death (yyyy/mm/dd)

Note: If you are adding or removing coverage due to another plan, no changes will be made until the letter * is received.

Late applicant provisions will apply if this form & letter are not received within 31 days of the change date.

Health (indicate dependent information under Add/Delete/Change Dependent(s))

Change to ___single coverage ___family coverage

___*Terminate coverage because I am covered under another health plan.

*Provide proof of new coverage, i.e. a letter from the administrator/insurer confirming:
Name of other insurer, policy number, date coverage effective, type of coverage.

If you are applying for health coverage as a result of losing coverage under another plan, you must provide proof of the loss in the form of a letter * from the administrator/insurer confirming: *name of the other insurer, policy number, date coverage ceases, type of coverage lost, reason for loss of coverage.*

Dental (indicate dependent information under Add/Delete/Change Dependent(s))

Change to ___single coverage ___family coverage

___*Terminate coverage because I am covered under another dental plan.

*Provide proof of new coverage, i.e. a letter from the administrator/insurer confirming:
Name of other insurer, Policy number, Date coverage effective, Type of coverage.

If you are applying for dental coverage as a result of losing coverage under another plan, you must provide proof of the loss in the form of a letter * from the administrator/insurer confirming: *name of the other insurer, policy number, date coverage ceases, type of coverage lost, reason for loss of coverage.*

Add/Delete/Change Dependent(s)

Action**	Relationship	Last name, First Name and Initials	Sex (M/F)	Date of birth (yyyy/mm/dd)	Dependent Status***
	Spouse				
	Child				
	Child				
	Child				
	Child				
	Child				

** D-Delete, A-Add, C-Change

***Child, Student (college/university), Disabled

Please indicate any other children on an additional form. If the dependent child is between 21 and 26, you must provide proof that your child is attending an accredited educational institution on a full-time basis. Acceptable proof includes a completed registration form that has been stamped "paid" by the university or college or a letter from the institution indicating your dependent has full-time student status for the coming year. Photocopies of student cards are not acceptable.

The original signed form is legally required for changes to your beneficiary information

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Dependent Life Insurance
__Terminate coverage effective (yyyy/mm/dd):_____
__Add coverage (must be added within 31 days of becoming a dependent)

Optional Life Insurance for myself
__Terminate coverage effective (yyyy/mm/dd):_____
__Reduce coverage effective (yyyy/mm/dd):_____ New lower amount:_____
To add or increase coverage, the optional life application and medical evidence form must be completed.

Optional Life Insurance for my spouse
__Terminate coverage effective (yyyy/mm/dd):_____
__Reduce coverage effective (yyyy/mm/dd):_____ New lower amount:_____
To add or increase coverage, the optional life application and medical evidence form must be completed.

Voluntary Accidental Death & Dismemberment Insurance
__Terminate coverage effective (yyyy/mm/dd):_____
To add, decrease or increase coverage, a new voluntary AD&D form must be completed.

Critical Illness for myself
__Terminate coverage effective (yyyy/mm/dd):_____
To add or increase coverage, the critical illness application must be completed.

Critical Illness for my spouse
__Terminate coverage effective (yyyy/mm/dd):_____
To add or increase coverage, the critical illness application must be completed.

Critical Illness for my dependent children
__Terminate coverage effective (yyyy/mm/dd):_____
To add or increase coverage, the critical illness application must be completed.

Beneficiary Designation for Basic Life and Basic Accidental Death and Dismemberment Insurance

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Name of Trustee(s) if Beneficiary(ies) is under age 18: _____

New Beneficiary(ies)

Last Name, First Name, Initial	Percentage	Relationship

If you are not survived by a living designated beneficiary, your life/AD&D insurance will be paid to your Estate.

I am applying for insurance coverage in accordance with the provisions and conditions of the Group Insurance Contract issued at the policyholder's request. I authorize the policyholder to deduct from my earnings any required contribution for the insurance to which I am or may be entitled. I authorize the use of my Social Insurance Number for group insurance identification purposes and as required by law, for income tax reporting.

_____ _____
Signature of Employee (must be signed in the presence of a witness) **Date (yyyy/mm/dd)**

_____
Signature of Witness

For office use only

_____ _____
Keyed by Date (yyyy/mm/dd)

The original signed form is legally required for changes to your beneficiary information