HEALTH ASSOCIATION NOVA SCOTIA

BENEFIT CHANGE OR CANCELLATION FORM

CHAN

TO BE COMPLETED BY THE EMPLOYEE. PLEASE USE CAPITAL LETTERS AND PRINT CLEARLY

Last Name	First Name	Middle initial	SIN
			- -

PLEASE READ CAREFULLY AND COMPLETE ONLY THE AREAS REQUIRING A CHANGE

OPTIONAL LIFE INSURANCE FOR MYSELF *(up to a principal sum of $500,000, in units of $10,000)*

❒ I want to apply for coverage (complete all of the following): Medical Questionnaire required – see below

Current Optional Life amount: New or Reduced Coverage: New total amount applied for:

$_____ (a) _____ (b) _____ (a+b)
(previously approved or evidence-free coverage)

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____ **Mandatory**: Complete Declaration of Smoker Status over

OPTIONAL LIFE INSURANCE FOR MY SPOUSE *(up to a principal sum of $500,000, in units of $10,000)*

❒ No coverage

❒ If applying within 60 days (complete all of the following):

Evidence-free coverage of: ❒ $10,000 ❒ $20,000 ❒ $30,000 ❒ $40,000 ❒ $50,000

Plus additional coverage of $ _____

Medical Questionnaire required – see below **Mandatory**: Complete Declaration of Smoker Status over

❒ If applying after 60 days (complete all the following): Medical Questionnaire required – see below

Current Optional Life amount: New or Reduced coverage: New total amount applied for:

$_____ (a) _____ (b) _____ (a+b)
(previously approved or evidence-free coverage)

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____ **Mandatory**: Complete Declaration of Smoker Status over

OPTIONAL LIFE INSURANCE FOR MY DEPENDENT CHILDREN

❒ No coverage

❒ $2,500 ❒ $5,000 ❒ $10,000

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____

CRITICAL ILLNESS FOR MYSELF *(up to a principal sum of $150,000, in units of $5,000, minimum of $10,000)*

❒ No coverage

❒ Evidence-free coverage of:

❒ $10,000 ❒ $15,000 ❒ $20,000 ❒ $25,000

❒ Plus additional coverage of: $_____ **Medical Questionnaire required – see below**

❒ New or Reduced Coverage (please specify): $_____

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____ **Mandatory**: **Complete Declaration of Smoker Status**

CRITICAL ILLNESS FOR MY SPOUSE *(up to a principal sum of $150,000, in units of $5,000, minimum of $10,000)*

❒ No coverage

❒ Evidence-free coverage of:

❒ $10,000 ❒ $15,000 ❒ $20,000 ❒ $25,000

❒ Plus additional coverage of: $_____ **Medical Questionnaire required – see below**

❒ New or Reduced Coverage (please specify): $_____

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____ **Mandatory**: **Complete Declaration of Smoker Status**

CRITICAL ILLNESS FOR MY DEPENDENT CHILDREN

❒ No coverage

❒ $10,000

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____

MEDICAL QUESTIONNAIRE

To apply for Optional Life or Critical Illness coverage, you must request a copy of the Medical Questionnaire from your Benefit Administrator for all amounts (other than evidence-free coverage). **Coverage takes effect once the Medical Questionnaire has been approved.**

Optional Life coverage is available evidence-free only if:

- You have a new spouse and are applying for coverage for your spouse within 60 days of marriage or one year of cohabitation

Critical Illness is available evidence-free only if:

- You are applying for up to $25,000 of Critical Illness coverage for yourself and/or your spouse.
- You are applying for $10,000 for your dependent children

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE *(up to a principal sum of $500,000, in units of $10,000)*

Category of coverage: ❒ Myself only ❒ Me and my family Change coverage to: ❒ Family ❒ Single

❒ New or Reduced Coverage (please specify): $_____

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____

PLEASE COMPLETE PAGE 2 ON OTHER SIDE →

DECLARATION OF SMOKER STATUS *(for Optional Life and Critical Illness for Yourself and your Spouse)*

If you are applying for coverage for the first time or your smoker status (or your spouse's smoker status, if applicable) has changed, complete this declaration of smoker status:

Member (complete only if changing your status):

Have you smoked cigarettes, cigarillos, cigars, pipes, e-cigarettes, chewing tobacco, nicotine gum or patches, or used tobacco in any other form within the last 12 months? ❒ Yes ❒ No

Date (MM/DD/YYYY) _____ Signature of Employee _____

Spouse (complete only if changing your status):

Have you smoked cigarettes, cigarillos, cigars, pipes, e-cigarettes, chewing tobacco, nicotine gum or patches, or used tobacco in any other form within the last 12 months? ❒ Yes ❒ No

Date (MM/DD/YYYY) _____ Signature of Spouse _____

HEALTH

❒ Change/Add: ❒ Single coverage ❒ Family coverage Effective date (MM/DD/YYYY): _____/_____/_____

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____ because I am covered elsewhere under another health plan (please provide name of other insurer, identification number and policy number).

Name of the other insurer: _____ Policy and Identification Number: _____

IMPORTANT NOTES:

If you choose to have extended health coverage and you experience a life event (new spouse, child), you have 60 days after the life event to make changes to your Health Care coverage. If you want to apply for coverage afterward, you and/or your dependent(s) will have to provide evidence of insurability as outlined in the group insurance contract. In this case, coverage becomes effective once the evidence of insurability has been approved. If you initially opt out because you are covered under your spouse's health plan, you do not have to submit evidence of insurability to join at a later date, provided you re-enrol within 60 days after losing coverage under your spouse's plan.

DENTAL

❒ Change/Add: ❒ Single coverage ❒ Family coverage Effective date (MM/DD/YYYY): _____/_____/_____

❒ Terminate coverage effective (MM/DD/YYYY): _____/_____/_____ because I am covered elsewhere under another dental plan * (please provide name of other insurer, identification number and policy number).

Name of the other insurer: _____ Policy and Identification Number: _____

IMPORTANT NOTES:

Benefits will be limited to $125 per person for the first year of membership if:

- you apply for coverage after the first 60 days during which you are eligible to join the Dental Care Plan;
- you opt out and re-apply for coverage after 60 days following the loss of coverage under your spouse's plan; or
- you move from single to family coverage but apply for such coverage after the first 60 days of acquiring your first eligible dependent (in this case, the $125 limit will apply to your dependents).

IF YOU ARE APPLYING FOR HEALTH AND/OR DENTAL COVERAGE AS A RESULT OF LOSING COVERAGE UNDER YOUR SPOUSE'S PLAN, PLEASE PROVIDE THE FOLLOWING DETAILS:

Name of the other insurer: _____ Effective date coverage ceases (MM/DD/YYYY): _____

Identification number: _____ Policy number: _____

DECLARATION AND AUTHORIZATION

I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, administering changes to benefits coverage, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependants, for the purposes of determining their eligibility for benefits and any of the uses set out above.

I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting. I authorize my employer to deduct from my earnings and required contributions for coverage under these plans.

Date (MM/DD/YYYY) _____ Signature of Employee _____

To be completed by the Employer. Please print.		
Name of Employee	SIN	Payroll Number
Name of Employer		ER Code
Name of Authorized Benefits Administrator (Please Print) Signature of Authorized Benefits Administrator		Date (MM/DD/YYYY)

Employer - Forward to Health Association Nova Scotia.