HEALTH ASSOCIATION NOVA SCOTIA

RETIREE CHANGE FORM
GROUP INSURANCE BENEFITS

RETC

Please complete the form using **UPPERCASE LETTERS**.

Last Name	First Name	Middle Initial	Certificate Number

E-Mail Address

❒ New Name

New Last Name	New First Name	Middle Initial

❒ New Address

Street and Number	City or Town	Province	Postal Code

❒ New Telephone Number

Area Code	Telephone Number

❒ New Marital Status (please indicate MM/DD/YY)

❒ Date of Marriage	❒ Date of Cohabitation (Common Law)	❒ Date Widowed	❒ Date of Divorce	❒ Date of Legal Separation

❒ New Spouse

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Gender

❒ Extended Health

❒ Change/Add	❒ Single Coverage	❒ Family Coverage	Effective Date (MM/DD/YYYY)
❒ Terminate coverage even though I am not covered elsewhere. I understand that I will not be eligible for retirement coverage at a later date.			
❒ Terminate coverage because I am covered under my spouse's health plan		Effective Date (MM/DD/YY)	

IMPORTANT NOTES:
If you choose to have extended health coverage and you experience a life event (change re: spouse, child), you have 60 days after the life event to make changes to your Health Care coverage.

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

Name of Other Insurer:	Effective Date Coverage Ceases (MM/DD/YYYY):
Identification Number:	Policy Number:

PLEASE COMPLETE PAGE 2 ON OTHER SIDE ⟶

❒ Change in Beneficiary - Basic Life Insurance

Subject to applicable legislation, I hereby designate the following to receive any benefits payable from the Basic Life Insurance Plan in the event of my death. I reserve the right to change my beneficiary designation. I understand that, if I do not designate a beneficiary, my estate will receive my benefits payable in the event of my death, in accordance with the laws of the area in which I reside. Health Association Nova Scotia assumes no responsibility for the validity or effect of this designation.

Last Name	First Name	Relationship	DOB: (MM/DD/YYYY)	% of Benefit
If any beneficiary is under age 18, please name a trustee:				**100%**

❒ CONTIGENT BENEFICIARY*

Last Name	First Name	Relationship	DOB: (MM/DD/YYYY)	% of Benefit
If any contingent beneficiary is under age 18, please name a trustee:				**100%**

*Contingent Beneficiary will receive any benefits payable from the Basic Life Insurance Plan in the event of the death of the named beneficiary.

❒ Cancel Basic Life Insurance

❒ I have opted to terminate my life insurance. **I UNDERSTAND THAT THE TERMINATION OF MY LIFE INSURANCE COVERAGE IS NOT REVERSIBLE.** I am aware that I do have the option to convert my coverage to a private plan as long as I do so within 31 days.

_____
Effective Date (MM/DD/YY)

DECLARATION AND AUTHORIZATION

I have verified the information on this form and declare that the statements are complete and true. Also, I authorize the use of my social insurance number for group insurance identification purposes and, as required by law, for income tax reporting.

_____ _____
Date (MM/DD/YY) Signature of Retiree

Please forward the original to:
Health Association Nova Scotia
Group Benefits Solutions
2 Dartmouth Road
Bedford NS B4A 2K7

THIS SECTION TO BE COMPLETED BY HEALTH ASSOCIATION NOVA SCOTIA:		
Retiree Name	CERT	Date of Birth (MM/DD/YY):
RBC Notified (MM/DD/YY):	PAP Cancelled or Changed (MM/DD/YY):	
_____ Signature of Benefits Administrator	_____ Date (MM/DD/YY)	