MUTUAL

CHANGE REQUEST - EMPLOYEE
GROUP INSURANCE

EMPLOYEE'S INFORMATION

NAME OF THE EMPLOYER	GROUP NO.	DIVISION NO.	CLASSE	EMPLOYEE NUMBER ID

EMPLOYEE LAST NAME	FIRST NAME	CERTIFICATE OF U.L. MUTUAL

☐ CHANGE OF COVERAGE
IF YOU HAVE CHOOSE FAMILY COVERAGE, PLEASE COMPLETE THE « DEPENDANTS » SECTION

NEW COVERAGE : ☐ SINGLE WITH DEPENDANT LIFE ☐ SINGLE ☐ COUPLE ☐ FAMILY ☐ SINGLE PARENT ☐ WAIVED ☐ OTHER _____

REASON: ☐ BIRTH ☐ ADOPTION ☐ CIVIL UNION ☐ MARRIAGE
BEGINNING OF COHABITATION Y M D
☐ DIVORCE ☐ END OF COHABITATION ☐ LOSS OF SPOUSE COVERAGE
EFFECTIVE DATE OF CHANGE Y M D

☐ DEPENDANTS

CHANGE	FAMILY NAME	FIRST NAME	SEX	DATE OF BIRTH	FULL-TIME STUDENT AGE 21 OR MORE	DISABLED DEPENDANT
☐ ADD SPOUSE ☐ DELETE SPOUSE ☐ CHANGE			☐ M ☐ F	Y M D		
☐ ADD CHILD ☐ DELETE CHILD ☐ CHANGE			☐ M ☐ F	Y M D	YES ☐ NO ☐	YES ☐ NO ☐
☐ ADD CHILD ☐ DELETE CHILD ☐ CHANGE			☐ M ☐ F	Y M D	YES ☐ NO ☐	YES ☐ NO ☐
☐ ADD CHILD ☐ DELETE CHILD ☐ CHANGE			☐ M ☐ F	Y M D	YES ☐ NO ☐	YES ☐ NO ☐

* PROOF OF FULL-TIME STUDY REQUIRED
** PROOF REQUIRED

☐ REFUSAL OF BENEFITS

WAIVE MYSELF AND MY DEPENDANTS : ☐ HEALTH CARE ☐ DENTAL CARE

WAIVE MY DEPENDANTS ONLY : ☐ HEALTH CARE ☐ DENTAL CARE

SPOUSAL NAME : _____ SPOUSAL PLAN NUMBER : _____ SPOUSAL CERTIFICATE NUMBER _____

SPOUSAL INSURER NAME : _____ EFFECTIVE DATE OF CHANGE : Y M D

☐ REINSTATEMENT OF BENEFITS

EFFECTIVE DATE OF LOSS OF COVERAGE THROUGH SPOUSAL PLAN : Y M D

REASON OF LOSS OF COVERAGE THROUGH SPOUSAL PLAN :

REQUIRED SIGNATURES

DATE _____ **EMPLOYEE SIGNATURE** _____

DATE _____ **PLAN ADMINISTRATOR SIGNATURE** _____

☐ BENEFICIARY DESIGNATION

NOTE: WHERE QUEBEC LAW APPLIES AND YOU HAVE DESIGNATED YOUR MARRIED SPOUSE OR CIVIL UNION SPOUSE AS BENEFICIARY, THE DESIGNATION WILL BE IRREVOCABLE UNLESS YOU CHECK THE BOX MARKED « REVOCABLE » BELOW.

	LAST NAME :	FIRST NAME :	RELATIONSHIP	
ACTUAL BENEFICIARY				☐ REVOCABLE ☐ IRREVOCABLE
NEW BENEFICIARY				☐ REVOCABLE ☐ IRREVOCABLE

FILL THIS SECTION ONLY IF THE CURRENT BENEFICIARY IS IRREVOCABLE

AS THE CURRENT IRREVOCABLE BENEFICIARY OF THE ABOVE MENTIONED POLICY, I HEREBY AGREE TO BE REVOKED AND I GIVE UP ALL MY RIGHTS AND PRIVILEGES UNDER THE TERMES OF THIS POLICY.

DATE _____ **CURRENT BENEFICIARY SIGNATURE** _____ **WITNESS SIGNATURE** _____

EMPLOYEE SIGNATURE

I HEREBY REVOKE ALL BENEFICIARY DESIGNATIONS MENTIONED ABOVE ET DESIGNATE THE FOLLOWING AS BENEFICIARY

DATE _____ **EMPLOYEE SIGNATURE** _____ **WITNESS SIGNATURE** _____

☐ CHANGE OF ADDRESS (NEW ADDRESS)

ADDRESS	CITY	PROVINCE	POSTAL CODE

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SALARY CHANGE

NEW SALARY : _____$ DATE OF CHANGE A M J

☐ ANNUAL ☐ WEEKLY ☐ HOURLY RATES NUMBER OF HOURS PER WEEK : _____

CHANGE OF CLASS OR DIVISION

☐ CHANGE OF CLASS NEW CLASS _____ DATE OF CHANGE A M J

☐ CHANGE OF DIVISION NEW DIVISION _____

NOTICE OF ABSENCE OF WORK

☐ TEMPORARY LAYOFF ☐ MATERNITY LEAVE DATE OF DEPARTURE A M J

☐ LEAVE WITHOUT PAY ☐ PARENTAL LEAVE

☐ OTHER _____ EXPECTED DATE OF RETURN A M J

NOTICE OF RETURN TO WORK

NEW SALARY : _____$ DATE OF RETURN TO WORK A M J

☐ ANNUAL ☐ WEEKLY ☐ HOURLY RATES NUMBER OF HOURS PER WEEK : _____

IS THE EMPLOYEE RETURNED TO HIS OWN OCCUPATION :

☐ YES, FULL-TIME ☐ YES PART-TIME / NUMBER OF HOURS PER WEEK _____

☐ NO, PLEASE EXPLAIN PLEASE EXPLAIN :

_____ _____

_____ _____

TERMINAISON

☐ WORK TERMINATION ☐ RETIREMENT DATE OF TERMINAISON A M J

☐ DEATH ☐ _____

COMMENTS

_____

_____

_____

_____

_____

SIGNATURE

_____ _____

DATE SIGNATURE OF THE POLICY ADMINISTRATOR