CHANGE FORM FOR STAFF PLAN MEMBERS

AOM Benefits Trust

Please complete Section 1 and the applicable sections for your change.
This form must be signed in ink and the original returned to your employer. Return a copy of this form to the AOM Benefits Trust by email, mail, or fax. Our contact information is on the second page.

1: PLAN MEMBER INFORMATION

Last name: | First name: | Middle initial: | Employer: AOM Benefits Trust

Class (plan member group): 002 - AOMBT staff | Effective date of change: YYYY - MM - DD | Primary phone number: | Email address:

2: ADDRESS CHANGE

Mailing address:

City/Town: | Province: | Postal code:

3: NAME CHANGE

◯ Plan member
◯ Spouse/partner
◯ Dependant

Last name on file: | First name on file: | Middle initial on file:

New last name: | **New first name:** | **New middle initial:**

4: BIRTH DATE CORRECTION

◯ Plan member ◯ Spouse/partner ◯ Dependant

Birth date on file: YYYY - MM - DD | **Correct birth date:** YYYY - MM - DD

5: EMPLOYMENT AND/OR SALARY CHANGE

New employment status:
◯ Full time ◯ Part time ◯ Terminated

Hours to be worked per week:

Salary on file: | **New annual salary** (must be within last 31 days):

6: COVERAGE CHANGE

Health (including paramedical, prescriptions, medical supplies and travel):
◯ Single ◯ Couple ◯ Family

Dental (including orthodontics):
◯ Single ◯ Couple ◯ Family

7: ADD OR DELETE A DEPENDANT

Spouse/partner
◯ Add
◯ Delete

Last name: | First name: | Middle initial:

Birth date: YYYY - MM - DD | Gender: ◯ M ◯ F | Date of marriage or common-law status (12 months cohabitation): YYYY - MM - DD

Child
◯ Add
◯ Delete

Last name: | First name: | Middle initial:

Birth date: YYYY - MM - DD | Gender: ◯ M ◯ F | Student (if 21 years or older): ◯ YES ◯ NO | Disabled: ◯ YES ◯ NO

Child
◯ Add
◯ Delete

Last name: | First name: | Middle initial:

Birth date: YYYY - MM - DD | Gender: ◯ M ◯ F | Student (if 21 years or older): ◯ YES ◯ NO | Disabled: ◯ YES ◯ NO

Reason for addition/removal:

8: BENEFCIARY CHANGE

If you designate a beneficiary who is:
a) under the age of majority, or b) mentally incapacitated, you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

*If you are a Quebec resident and you designate your spouse as your beneficiary, you are not permitted to change that beneficiary unless you:
a) indicate that your designation of beneficiary is revocable, by checking the box on this form, or b) your spouse agrees, in writing, to be removed as your beneficiary.

****If you are a resident of a province other than Quebec, your beneficiary designation is automatically revocable (changeable) unless you specifically make it irrevocable. If you make an irrevocable beneficiary designation, you will not be able to alter or change your beneficiary designation in any way without the consent of the beneficiary. If your beneficiary is a minor, you will not be permitted to alter or change your beneficiary designation in any way until your beneficiary reaches the age of majority.** You should consider obtaining legal and financial advice from a professional advisor before making any irrevocable beneficiary designation.

Original beneficiary information will be kept by your employer.

Name your beneficiary or beneficiaries

Last name:	First name:	Middle initial:	Date of birth:	Gender:	Relationship to plan member:	Beneficiary Revocable? ** see above	Percent allocated:
				○ M ○ F		○ Yes ○ No	
				○ M ○ F		○ Yes ○ No	
				○ M ○ F		○ Yes ○ No	
				○ M ○ F		○ Yes ○ No	
					Total value must equal 100%	**TOTAL**	

I appoint _____ as trustee to receive any amount designated to a beneficiary who is under the age of majority or mentally incapacitated.

In the event the primary beneficiary or beneficiaries predeceases the plan member, the following contingent beneficiary or beneficiaries shall be entitled to the benefits:

Last name:	First name:	Middle initial:	Date of birth:	Gender:	Relationship to plan member:	Beneficiary Revocable? ** see above	Percent allocated:
				○ M ○ F		○ Yes ○ No	
				○ M ○ F		○ Yes ○ No	

For Quebec residents only*: If you have designated your spouse as beneficiary, the designation will be irrevocable unless you indicate that you wish it to be revocable below.

I wish to make my designation: ○ Revocable ○ Irrevocable

9: PLAN MEMBER DECLARATION

I consent to the collection, use and exchange of my personal information by my employer, plan administrator, an insurance company, and/or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependant children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependant children over the age of majority, to share information as it relates to the plan.

I hereby apply for group benefits under my employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrollment form will be retained by my employer.

I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time.

Plan member signature :	Date signed:	Employer signature:	Date signed: