CHANGE FORM FOR MIDWIVES

AOM Benefits Trust

Please complete Section 1 and the applicable sections for your change.
This form must be signed in ink. If you are changing your beneficiary designation, please return the original signed form by mail to the AOM Benefits Trust. All other changes can be sent by email, mail, or fax.
Our contact information is on the second page.

1: PLAN MEMBER INFORMATION

AOM number:	Last name:	First name:	Middle initial:
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: COVERAGE CHANGE

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

5: OPTIONAL INSURANCES TERMINATION

Changes indicated below apply only to any optional (additional) AD&D and/or Critical Illness insurance you have purchased and will not affect your enrollment in the mandatory insurances (Basic Life, Basic AD&D, Basic Critical Illness). Click here to download the form to terminate optional/spousal Life Insurance. Contact the AOM Benefits Trust for information about applying for optional insurances.

Please terminate (cancel):

☐ Optional AD&D ☐ Spousal AD&D ☐ Family AD&D ☐ Optional Critical Illness ☐ Spousal Critical Illness ☐ Child Critical Illness

6: ADD OR DELETE A DEPENDANT

Spouse/ partner ◯ Add ◯ Delete	Last name:		First name:		Middle initial:
	Birth date: YYYY - MM - DD	Sex: ◯ 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	Sex: ◯ 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	Sex: ◯ M ◯ F	Student (if 21 years or older): ◯ YES ◯ NO	Disabled: ◯ YES ◯ NO	

Reason for addition/removal:

7: BENEFICIARY 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.

Original beneficiary information will be kept by your plan sponsor.

Name your beneficiary or beneficiaries

Last name:	First name:	Middle initial:	Date of birth:	Sex:	Relationship to plan member:	Percent allocated:
				◯ M ◯ F		
				◯ M ◯ F		
				◯ M ◯ F		
				◯ M ◯ F		
				Total value must equal 100%	**TOTAL**	

I appoint_____________________ as trustee to receive any amount designated to a beneficiary who is under the age or 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:	Sex:	Relationship to plan member:	Percent allocated:
				◯ M ◯ F		
				◯ M ◯ F		

8: PLAN MEMBER DECLARATION

I consent to the collection, use and exchange of my personal information by my 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 plan administrator'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 plan administrator.

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: YYYY - MM - DD	Plan administrator signature:	Date signed: YYYY - MM - DD