

Application for Change

Plan Member Information

Municipality Name

Plan Member/Employee Name

Termination of All Coverage

Reason for Termination

Date Last Worked (yy/mm/dd)

If employee is retiring, please offer the AMM Retiree Plan as soon as possible. Employee must apply within 31 days of retirement.

Name Change

Employee's Name From

Employee's Name To

Request must be completed within 31 days of marriage or divorce.

Change of Coverage Designation

Change to Family Coverage Yes

Please Complete one of the following:

- | | | | | |
|---|--|---|---------------|-----------------------------------|
| 1. Change due to Marriage | 12 Months Co-Habitation | Date of Marriage/Co-habitation (yy/mm/dd) | Spouse Name | Spouse's Date of Birth (yy/mm/dd) |
| 2. Change due to termination of spouse's insurance plan | Confirmation required, i.e. employer's letter to insurance company or letter from insurance company. | Date of Termination of Spouse's Plan (yy/mm/dd) | Spouse Name | Spouse's Date of Birth (yy/mm/dd) |
| 3. Change due to addition of a dependent child. | Reason for Addition of Dependent Child | Child Name | Sex
M
F | Child's Date of Birth (yy/mm/dd) |
| | Reason for Addition of Dependent Child | Child Name | Sex
M
F | Child's Date of Birth (yy/mm/dd) |

Family coverage must be applied for within 31 days from the date of Change or Medical Evidence will be required.

Change to Family Coverage Yes

Please Complete one of the following:

- | | | | |
|--|--|--|------------------------------------|
| 1. Change due to spouse obtaining insurance plan | Spouse's Coverage includes Health Dental | Effective Date of Spouse's Coverage (yy/mm/dd) | Spouse's Coverage is Single Family |
| | Spouse's Insurance Carrier | Policy Number | |
| 2. Change due to separation, divorce, or death of spouse | Date of Separation/Divorce (yy/mm/dd) | Date of Death (yy/mm/dd) | |

Waive Health & Dental Coverage Yes

Waiver of Health and Dental Benefits are only permitted if similar coverage is provided through your spouse's plan.

Spouse's Coverage includes Health Dental
Spouse's Insurance Carrier

Effective Date of Spouse's Coverage (yy/mm/dd)
Policy Number

Certification and Authorization

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group's commitment to privacy and security refer to our web site: www.westernfg.ca

Employee Signature

Date Signed (yy/mm/dd)