Assumption Life
Group Insurance

Reset

Group Insurance Policy Service Request

TO BE COMPLETED BY THE EMPLOYEE

First name _____ Last Name _____ Policy _____ Division _____ Certificate _____

A. CONTACT INFORMATION CHANGE

Address _____ City _____ Province _____ Postal Code _____

Telephone Number (____)_____ - _____ Home (____)_____ - _____ Office (____)_____ - _____ Cell

E-mail _____

B. CHANGE OF BENEFICIARY

PRIMARY BENEFICIARY First Name / Last Name	Date of Birth (DD/MM/YYYY)	%	Revocable	Irrevocable	Relationship to employee
			☐	☐	
			☐	☐	
			☐	☐	
Total (must be equal to 100%)					

CONTINGENT BENEFICIARY First Name / Last Name	Date of Birth (DD/MM/YYYY)	%	Revocable	Irrevocable	Relationship to employee
			☐	☐	
			☐	☐	
			☐	☐	
Total (must be equal to 100%)					

If the beneficiary is a minor, please designate a trustee: _____

Relationship of the trustee to the employee: _____

Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocable, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary. In Quebec, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. The policy does not confer any rights to contingent beneficiaries prior to the death of the primary beneficiaries.

C. CHANGE OF NAME

Please be advised that my name has been changed to: _____ First Name _____ Last Name

This change is effective on: __/__/____ DD MM YYYY

Reason for name change: ☐ Marriage ☐ Divorce ☐ Other

Note: A name change due to a change in marital status may also require a change in dependent coverage. Please review section D.

D. DEPENDENT INFORMATION CHANGE

Change to: ☐ Single ☐ Family ☐ Single-Parent* ☐ Couple*

* If not provided under your contract, this will be considered as family coverage.

Effective date: ____/____/_____ DD MM YYYY

Reason: ☐ Birth ☐ Divorce ☐ Marriage ☐ Cohabitation

Date of marriage/ Cohabitation start date: ____/____/_____ DD MM YYYY

	First Name	Last Name	Gender	Date of Birth (DD/MM/YYYY)
Spouse*: ☐ Add ☐ Remove			☐ M ☐ F	
Children: ☐ Add ☐ Remove			☐ M ☐ F	
Children: ☐ Add ☐ Remove			☐ M ☐ F	

* If spouse has other coverage, please review section E.

Employee's Signature

I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my knowledge and authorize the company to make the specified changes.

_____ Employee's Signature

_____ Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 1-855-401-9068 E-mail: group@assumption.ca

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E. COORDINATION OF BENEFITS

Does your spouse have health coverage under his/her own insurance plan? ☐ Yes ☐ No Effective Date ____/____/_____ DD MM YYYY

If yes, is the health coverage an/a: ☐ Individual plan ☐ Family plan

Does your spouse have dental coverage under his/her own insurance plan? ☐ Yes ☐ No Effective Date ____/____/_____ DD MM YYYY

If yes, is the dental coverage an/a: ☐ Individual plan ☐ Family plan

Name of Spouse's Insurer: _____ Contract Number: _____

F. REFUSAL OF HEALTH AND/OR DENTAL BENEFITS

Comment : All benefits under your group insurance plan are mandatory. However, you may waive the health and dental benefits if you have similar coverage under your spouse's plan.

I understand the terms and conditions of the group insurance plan that is being offered, but I waive the following benefits:

		Myself and my dependents	My dependents
Effective Date: ___/___/_____ DD MM YYYY	**Health Insurance**	☐	☐
	Dental Insurance	☐	☐

If coverage under your spouse's plan is discontinued, you will have 31-day period in which to submit an application for coverage. After this date, you and your dependents must submit proof acceptable to Assumption Life in order to be covered. Upon approval of your membership, if need be, the dental insurance will be limited.

Name of Spouse's Insurer: _____ Contract Number:_____

Employee's Signature

I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my knowledge and authorize the company to make the specified changes.

_____ _____

Employee's Signature Date (DD/MM/YYYY)

TO BE COMPLETED BY THE EMPLOYER

G. SALARY CHANGE

Salary $_____ ☐ hourly ☐ weekly ☐ monthly ☐ yearly Effective date (DD/MM/YYYY) ____/____/_____

H. TERMINATION OF COVERAGE

Please cancel the insurance of the above-mentioned employee as of ____/____/_____.
Reason ☐ Termination of employment ☐ Temporary layoff ☐ Other (specify) _____

I. RETURN TO WORK

Employee has resumed duties as of (DD/MM/YYYY) ____/____/_____.

Employer's Signature

I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my knowledge and authorize the company to make the specified changes.

_____ _____

Employer's Signature Date (DD/MM/YYYY)

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P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 1-855-401-9068 E-mail: group@assumption.ca