

Coughlin & Associates Ltd. P.O. Box 764 Winnipeg, MB R3C 2L4 Ph. (204) 942-4438 1-888-204-1234

CHANGE FORM - DEPENDENT COVERAGE - BENEFICIARY DESIGNATION -

Please complete the **applicable** sections and **sign and date** the reverse side. Return the form for processing.

Note: this form can only be used for changes to your existing records. When enrolling for the first time, please complete an **Application for Group Coverage.**

PLAN ME	MBER'S INFO	DRMATION								
Local Union	or Employer: Al	berta Sheet Meta	al Worker's Healtl	n & Welfare Plan						
Name of Pla	n Member:									
Mailing Address: 0				ity and Province:		Postal Code:				
				Email Address:						
Social Insurance Number:			Date of Birth: day / month / year							
CHANGE IN RELATIONSHIP STAT			IS	Add		Remove				
Date of Marriage	e or Commencement o	f Common-Law Relati	onship							
day	month	year								
Date of Separation or Divorce or Co-habitation			Change of Status due to:							
day	month	year	Single	☐ Married	☐ Comm	on-Law	☐ Wid	owed		
			☐ Separated	Divorced	☐ Cessati	on of co-habitatic	on			
		OF DEPEND the following dep		ny group benefit plan	:					
Spouse/Partner's Information				What group benefits coverage does your spouse have through an employer?			employer?			
				Healthcare	→ Does	this include pres	cription drug	j coverage?		
last name	first	name	middle initial	☐ Single ☐ Family ☐	Waived \[\] No	one \square	Yes	10		
date of birth (day/month/year)		_	Gender Dentalcare Visioncare							
			Male Female	☐ Single ☐ Family ☐ \	Vaived ☐ None	☐ Single ☐ F	amily 🗌 Wa	ived None		
In the case of	f children of a cor	nmon-law spouse	, I certify that thes	e children reside with	me and are	dependent up	on me for	support.		
<u>Dependent(s) Information</u> If there are more than four dependants, please attach a separate list.			Date of Bi	rth Relationship	to Insured	Gender	Full time Student	Disabled Dependent		
last name	first name	middle initial	(day / month /	year)		Male Female	Yes No	Yes No		
last name	first name	middle initial	(day / month /	year)		Male Female	Yes No	Yes No		
last name	first name	middle initial	(day / month /	year)		Male Female	Yes No	Yes No		

GROUP OR EMPLOYER:	:					
Plan Member's name :			Date:			
CHANGE IN BENEFICIAL I hereby revoke all previous beneficion Health and Welfare Plan upon my dwill not be revoked or changed autoor divorce, you will have to do so by equal 100%.	iary designations and appoi eath, and discharge the Tru omatically by any future man	nt the following revocable beneficial istees of the Plan to the extent of surriage or divorce. Should you wish t	ich payment. (Note: Your o o change your beneficiary i	designation of a beneficiary in the event of a future marriage		
Beneficiary's Name(s)			Percent allocated	Relationship to Plan Member		
last name	first name	middle initial				
last name	first name	middle initial				
last name	first name	middle initial				
Contingent beneficiary – or Sec plan is to be paid to:	condary beneficiary in th	e event the beneficiary(ies) dies b	pefore me, the life benefit	set out in the Group Insurance		
Name of contingent beneficiary			Relationship to Plan Member			
If designating a beneficiary who is	, ,			ust appoint a trustee/administrator.		
Trustee Name		Relationship to plan member		_		
	Note: Not required if the	ne plan member has already co	mpleted a written Trust	Agreement.		
Signature of Plan Member:			Date:	D / M / Y		

PLEASE RETURN TO COUGHLIN & ASSOCIATES LTD.