ContinYou™

JG11-CY

COVERED INDIVIDUAL CHANGE REQUEST

Please print your Policy & Certificate #

Policy #	Certificate #

Covered Individual's Name _____

Check the changes you are making and provide ALL the information requested for EACH section you check.

❑ **Address Change**	New Address		
❑ **Covered Individual Name Change**	Previous Name	Date of Change (YYYY/MM/DD)	
	Reason for Change		
❑ **New Marital Status** (If checked, please see *Dependent Status* below)	❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced	Date (YYYY/MM/DD)	
	❑ Common Law (Please provide date you began living together)		
❑ **Add Benefits**	❑ Health ❑ Dental (Complete *Dependent Status* if requesting family coverage) Previously covered under another plan? ❑ No ❑ Yes, up to (YYYY/MM/DD)		
❑ **Dependent Status**	❑ Change from family to single coverage Reason	Date of Change (YYYY/MM/DD)	
	❑ Change from single to family coverage Reason	Date of Change (YYYY/MM/DD)	

List all your dependents affected by the change, including your spouse:

	Date of Change (YYYY/MM/DD)	First and Last Name	Relationship*	Birthdate (YYYY/MM/DD)	Gender
❑ Add ❑ Change ❑ Delete					
❑ Add ❑ Change ❑ Delete					
❑ Add ❑ Change ❑ Delete					
❑ Add ❑ Change ❑ Delete					

***If a dependent is disabled, please complete the *Request for Over-Age Disabled Dependent Coverage* form. If a dependent is an over-age dependent, please complete the *Request for Over-Age Dependent Coverage* form.**

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

I authorize Johnston Group Inc. and Co-operators Life Insurance Company to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.johnstongroup.ca.

A photocopy of this authorization is as valid as the original.

Employee's Signature _____ Date _____

NATIONAL SERVICE CENTRE, 1051 King Edward Street, Winnipeg, MB R3H 0R4