Retiree Plans

Johnston group

JG21-JG

COVERED INDIVIDUAL CHANGE REQUEST

Please indicate your Firm & Certificate #

Firm #	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)		
❑ **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)	

After a minimum of 3 years participation under the JG Retiree Plan, an individual may choose to elect a lesser plan. The change will be effective the latter of the first of the month following receipt of the request and your satisfying the minimum 3 years participation. Indicate your selection to change plans by choosing from the following:

I currently hold $25,000 Life
I choose to select ❑ $15,000 or ❑ No life coverage

I currently hold $15,000 Life
I choose to select ❑ No life coverage

I currently hold benefits under Plan A
I choose to select ❑ Plan B or ❑ Plan C

I currently hold benefits under Plan B
I choose to select ❑ Plan C

I currently hold Drug Option 1
I choose to select ❑ Drug Option 2 or ❑ No drug coverage

I currently hold Drug Option 2
I choose to select ❑ No drug coverage

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					

***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 The Co-operators, Group Medical Services (GMS), Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. 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.

Covered Individual's Signature _____ Date _____

NATIONAL SERVICE CENTRE
1051 King Edward Street, Winnipeg, MB R3H 0R4 • 1-800-893-7587

Underwritten by The Co-operators and Group Medical Services (GMS).