Retiree Plans
Johnston group For Employees

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**			
Date of Change (YYYY/MM/DD)	❑ Change from single to couple coverage	Reason	
Date of Change (YYYY/MM/DD)	❑ Change from single to family coverage	Reason	
Date of Change (YYYY/MM/DD)	❑ Change from couple to family coverage	Reason	
Date of Change (YYYY/MM/DD)	❑ Change from family to couple coverage	Reason	
Date of Change (YYYY/MM/DD)	❑ Change from couple to single coverage	Reason	
Date of Change (YYYY/MM/DD)	❑ Change from family to single coverage	Reason	

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 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 _____