Application for Change

TotalGuard

Plan Member Information

Firm Name

Employee Name

Termination of All Coverage

Reason for Termination

Date Last Worked (yy/mm/dd)

Salary Change

Gross Earning

$ ☐ Annual ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Hourly

Effective Date (yy/mm/dd)

Hours Worked Per Week

Name Change

Employee's Name From

Employee's Name To

Request must be completed within 31 days of marriage or divorce.

Other

Change of Coverage Designation

Change to Family Coverage ☐ **Yes** ☐ **No**

If yes, please complete one of the following:

1. Change due to
   ☐ Marriage ☐ 12 Months Co-Habitation
   Date of Marriage/Co-habitation (yy/mm/dd)
   Spouse Name
   Sex ☐ M ☐ F ☐ U
   Spouse's Date of Birth (yy/mm/dd)

2. Change due to termination of spouse's insurance plan
   Confirmation required, i.e. employer's letter to insurance company or letter from insurance company.
   Date of Termination of Spouse's Plan (yy/mm/dd)
   Spouse Name
   Sex ☐ M ☐ F ☐ U
   Spouse's Date of Birth (yy/mm/dd)

3. Change due to addition of a dependent child
   Reason for Addition of Dependent Child
   Child Name
   Sex ☐ M ☐ F ☐ U
   Child's Date of Birth (yy/mm/dd)

   Reason for Addition of Dependent Child
   Child Name
   Sex ☐ M ☐ F ☐ U
   Child's Date of Birth (yy/mm/dd)

Family coverage must be applied for within 31 days from the date of Change or Medical Evidence will be required.

Change to Single Coverage ☐ **Yes** ☐ **No**

If yes, please complete one of the following:

1. Change due to spouse obtaining insurance plan
   Spouse's Coverage includes ☐ Health ☐ Dental
   Effective Date of Spouse's Coverage (yy/mm/dd)
   Spouse's Coverage is ☐ Single ☐ Family
   Spouse's Insurance Carrier
   Policy Number

2. Change due to separation, divorce, or death of spouse
   Date of Separation/Divorce (yy/mm/dd)
   Date of Death (yy/mm/dd)

Change to Partial Coverage ☐ **Yes** ☐ **No**

Waiver of Health and Dental Benefits are only permitted if similar coverage is provided through your spouse's plan.

If yes, please complete one of the following:

Spouse's Coverage includes ☐ Health ☐ Dental

Effective Date of Spouse's Coverage (yy/mm/dd)

Spouse's Insurance Carrier

Policy Number

Certification and Authorization

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group's commitment to privacy and security refer to our web site: www.westernfg.ca

Employer Signature

Date Signed (yy/mm/dd)

Western FINANCIAL GROUP
Canada's Insurance Broker

Complete and send to:
TotalGuard, Western Financial Group
201-600 Empress Street, Winnipeg, Manitoba R3G 0R5
Fax: 204-943-5532