



Please print clearly in INK. Once you have completed this form and attached any additional documentation required, you must mail the original form to D&R Insurance Administration Inc., address found at the bottom of this form. If you have any questions, please call D&R Insurance at 905.819.9699 or toll free 1.800.521.0023.

EMPLOYEE INFORMATION	First Name	Last Name	Initial
	Policy #	Certificate No.	

ADDRESS UPDATE	This section is to report a new mailing address.				
	Address	City	Province	Postal Code	Phone No.
ON ()					

NAME CHANGE	This section to be completed for name change as a result of marriage, divorce or for other reasons.					
	From:	Last Name	First Name	To:	Last Name	First Name

BENEFIT CHANGE	This section to be completed if you wish to make a change in your Benefit coverage.		
	Benefit(s) you would like to add	Benefit(s) you would like to terminate	Effective Date (DD/MM/YY)
<input type="checkbox"/> Healthcare <input type="checkbox"/> Dental		<input type="checkbox"/> Healthcare <input type="checkbox"/> Dental	

WAIVER OF BENEFITS	This section is for Health and/or Dental coverage which you may wish to refuse.	
	I understand the group benefits that are offered to me, but I decline to participate in:	Effective Date (DD/MM/YY)
	Healthcare for <input type="checkbox"/> myself OR <input type="checkbox"/> myself and my dependents OR <input type="checkbox"/> my dependents only	
	Dental for <input type="checkbox"/> myself OR <input type="checkbox"/> myself and my dependents OR <input type="checkbox"/> my dependents only	
	IMPORTANT From the date of change you have 31 days to notify D&R Insurance of this change. After 31 days you will be subject to medical approval by the insurance company and any costs associated with this adjudication will be your responsibility. You may also be subject to a decrease in coverage for the first year.	

DEPENDENT INFORMATION CHANGE	This section must be completed if you are adding or deleting a dependent, or updating dependent information. If there are more than four dependents, please attach a separate list.
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Effective Date of Change (DD/MM/YY) _____ Change Coverage to _____

Single Coverage Family Coverage

Reason for Change:	Date Common Law Commenced (DD/MM/YY)
<input type="checkbox"/> Birth of Child <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Marriage <input type="checkbox"/> Common Law	

Spouse Information	First Name	Last Name	Initial	Date of Birth (DD/MM/YY)	Gender M F
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Name Change					<input type="checkbox"/> <input type="checkbox"/>

INITIALS _____

DEPENDENT INFORMATION CHANGE

What group benefits coverage does your spouse have through an employer?

HEALTH CARE Single Family Waived None Does this include prescription drug coverage? Yes No

DENTAL CARE Single Family Waived None VISION CARE Single Family Waived None

Dependent Information	First Name	Last Name	Initial	Date of Birth (DD/MM/YY)	Gender		Full Time Student		Disabled	
					M	F	Yes	No	Yes	No
<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL NOTE:
If you have checked YES for Full-Time Student and/or Disabled Dependent, please contact your Client Service Representative at D&R Insurance to review eligibility requirements.

BENEFICIARY CHANGE

This section must be completed to change the designated beneficiary or beneficiaries for your Life Insurance.

Beneficiary's Name(s)	First Name	Last Name	Initial	Percentage Allocated	Relationship to Plan Member	Date of Birth (DD/MM/YY)
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent						
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent						
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent						

In the event that the Primary or Contingent Beneficiary(ies) dies and no percentage has been allocated in the appropriate box. The benefit will be split into equal shares. If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee by completing the section below. If you are designating a trustee, we recommend you consult any proposed trustee and a legal advisor.

TRUSTEE FOR BENEFICIARY UNDER 18 YEARS OLD

First Name	Last Name	Initial	Relationship to Plan Member

I hereby appoint the above named Trustee to receive any payment due on or after the Life Insured's death on behalf of any minor beneficiary.

PRIVACY	<p>Protecting Your Personal Information</p> <p>At D&R Insurance, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of D&R Insurance or the offices of an organization authorized by D&R Insurance. We limit access to information in your file to D&R Insurance staff or persons authorized by D&R Insurance who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefits plan.</p>
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AUTHORIZATIONS AND DECLARATIONS	<p>I hereby apply for coverage under the group benefits plan issued by D&R Insurance.</p> <p>I authorize:</p> <ul style="list-style-type: none"> • My employer to deduct premiums from my salary and remit them to D&R Insurance, if applicable; • D&R Insurance to deduct from my bank account, if applicable and pre-authorization forms are completed; • D&R Insurance, any healthcare provide, my employer, my local, other insurance companies, or benefit providers working with D&R Insurance to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefits plan. <p>If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.</p> <p>I agree that a photocopy or electronic copy of this Authorization and Declaration Section is as valid as the original.</p> <p>I certify that the information given is true, correct and complete to the best of my knowledge.</p>
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SIGNATURE AND DATE	AUTHORIZED SIGNATURE	DATE (DD/MM/YYYY)