Desjardins Financial Security®

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

GROUP INSURANCE - CONTRACT ADMINISTRATION

MEMBER'S CHANGE REQUEST

A group benefits plan insured by Desjardins Financial Security and administered by: CBIA AABC ®

To ensure approval of adequate coverage, please submit all changes within 31 days of the insurance eligibility date. To change a beneficiary, please use form No. 2000702A.

A - IDENTIFICATION – Please print

Name of policyholder		Group number
THE CANADIAN BAR INSURANCE ASSOCIATION		**00055010**
Last name of member	First name	Certificate number

B - CHANGE OF COVERAGE

Coverage requested: ☐ individual ☐ family

Event: ☐ spouse's loss of employment ☐ marriage ☐ separation or divorce ☐ birth

☐ start of common-law relationship (Common-law spouse is eligible for benefits after 12 months of cohabitation) ☐ other, specify: ____________

Date of event YYYY MM DD

C - ADDITION OF ELIGIBLE DEPENDENTS

Last name and first name	Sex M / F	Relationship with member (spouse, child)	Date of birth YYYY MM DD	Dependent's status S = age 21 to 25, full-time student X = Functional impairment	Covered under another plan Health Yes/No	Covered under another plan Dental Yes/No

D - DELETION OF ELIGIBLE DEPENDENTS

I no longer want my plan to cover the following dependents:

	Effective date YYYY MM DD
Last name, first name:	
Last name, first name:	

E - REQUEST FOR EXEMPTION

EXEMPTION - If my plan allows, I waive coverage under this(these) benefit(s): ☐ health insurance ☐ dental care since I am already covered under my spouse's plan.

Date of the event: ____________ YYYY MM DD

TERMINATION OF EXEMPTION - As I am no longer covered by my spouse's plan, I wish to be covered again under this(these) benefit(s):

☐ health insurance ☐ dental care

Date of the event: ____________ YYYY MM DD

Coverage requested: ☐ individual ☐ family

F - ☐ MATERNITY LEAVE ☐ TEMPORARY LAYOFF ☐ PARENTAL LEAVE ☐ UNPAID LEAVE

Please check the provisions provided under your plan

I wish to: ☐ keep the benefits provided by my group insurance plan.

☐ cancel all benefits under my group insurance plan **excluding the one that includes prescription drug coverage (Québec only).**

☐ cancel the disability income insurance under my group insurance plan.

Date of beginning of leave: ____________ YYYY MM DD

Expected return to work date: ____________

Signature of member ____________ **Signature of authorized person** ____________ **Date** ____________

Please give a copy to the member

® Registered trademark owned by Desjardins Financial Security