



Empire Life™

Insured Employee Information Change Form

Include reference to only one Insured Employee on each use of this form.

Policyowner: _____ Group Number: _____
Insured Employee: _____ Certificate Number: _____

Requested Change(s) for the above noted Certificate:

- Change of Beneficiary (complete Section 1 below)
- Change of Insured's Name or Address (complete Section 2 below)
- Insured Employee Banking Information (complete Section 3 below)
- Common Law Spouse Memorandum (complete Section 4 on reverse)
- Refusal/Waiver of Benefits (complete Section 5 on reverse)

Section 1 - CHANGE OF BENEFICIARY

I, the undersigned, do hereby revoke all previous beneficiary designations and declare that at my death all insurance proceeds under the above policy shall be payable to:

Beneficiary Designation

Last Name	First Name	Relationship	Percentage Split
_____	_____	_____	_____
_____	_____	_____	_____

If the Beneficiary is a minor, a trustee must be appointed. Trustee: _____

Revocable (Consent of beneficiary is not required to change designation.) Irrevocable (Consent of beneficiary is required to change designation.)

Where Quebec Law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: revocable

IRREVOCABLE BENEFICIARY

I, the irrevocable beneficiary hereby give my consent to the above change.

(Signature of Irrevocable Beneficiary) Date _____

(Signature of Insured) Date _____

Section 2 - CHANGE OF INSURED'S NAME OR ADDRESS

New Name _____ (Print name in full) Old Address _____
New Address _____

Please indicate why change is being made: _____

Date of Marriage _____

Other _____ (give details) Date of Change _____

The Empire Life Insurance Company assumes no responsibility for the sufficiency or validity of the above change of name.

(Signature of Insured) Date _____

Section 3 - INSURED EMPLOYEE BANKING INFORMATION (used for Deposit of Dental claim payments, when applicable).

Bank Transit Number	Bank Institution Number	Account Number
_____	_____	_____

Please attach a void cheque. Provision of your banking information will provide you with the convenience of electronic deposit of claim payments into the bank account specified.

Section 4 - COMMON LAW SPOUSE MEMORANDUM

To be completed by the insured whenever the employee has a common-law spouse.

Provincial Health Care Coverage in place for dependant(s) Y / N

Dependant's Name	Date of Birth	Relationship (Child/Spouse)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of Commencement of Cohabitation _____

Insured Employee's Signature _____

Employer Signature _____

Section 5 - REFUSAL OF ALL BENEFITS / WAIVER OF COVERAGE

Coverage Refusal/Waiver - Understanding the Choice

In respect of total Refusal of, or Waiver of (see Refusal and Waiver options below) any coverage under this Group Plan, I acknowledge that I have been offered the benefits of my employer's Group Insurance Plan with The Empire Life Insurance Company and the benefits provided by this Plan have been fully explained to me. I further acknowledge that I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits. I understand that if I apply for refused or waived coverage in the future, I may be requested to provide evidence of insurability at my own expense.

Total Refusal of Coverage

(Only available under plans with Non-Mandatory participation requirements. See your Plan Administrator for details.)

I waive total coverage for me and my dependants, if any. Effective Date _____

Waiver of Extended Health and/or Dental Coverage (Spousal Opt Out)

I, and/or my dependants have coverage with my spouse's group insurance plan and, I/we do not wish to co-ordinate benefits through both plans and therefore I wish to waive the following coverages:

- I waive Extended Health coverage for me and my dependants, if any.
- I waive Dental coverage for me and my dependants, if any.
- I waive Extended Health coverage for my dependants only.
- I waive Dental coverage for my dependants only.

Spouse's Insurance Company: _____ Type of Spouse's coverage: Single Family

Note: *Family coverage will be provided until spouses Insurance carrier information is provided.* Effective Date _____

In respect of Refusal of any, or all coverage under this Group Plan, I fully understand the rights to coverage I am forfeiting, as indicated above.

Employee's Signature X _____ Date _____

In respect of Refusal of, or Waiver of any coverage under this Group Plan, I have fully explained the rights the employee is forfeiting, as indicated above.

Employer's Signature X _____ Date _____