



Public Service Alliance of Canada
Alliance de la Fonction publique du Canada

Policy: GL 17700

Policy: C010367302

BENEFIT CHANGE FORM

Please complete this form in INK and print clearly.



PLAN MEMBER INFORMATION				
MEMBER SURNAME		GIVEN NAME		INITIAL
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH year month day		STREET ADDRESS	
CITY	PROVINCE	POSTAL CODE	TELEPHONE ()	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-law	REFERENCE NUMBER			

I hereby request that the optional life insurance or optional critical illness be modified as follows:

TERMINATION OF COVERAGE

- Member
- Spouse (name):
- Child (name):

DECREASE IN AMOUNT OF COVERAGE

Decrease coverage amount for the following: please select: Optional Life or Critical Illness

- | | |
|--|--|
| <input type="checkbox"/> Member (Check only one of the following choices) | <input type="checkbox"/> Spouse (Check only one of the following choices) |
| <input type="checkbox"/> \$ 25,000 <input type="checkbox"/> \$ 150,000 | <input type="checkbox"/> \$ 25,000 <input type="checkbox"/> \$ 150,000 |
| <input type="checkbox"/> \$ 50,000 <input type="checkbox"/> \$ 175,000 | <input type="checkbox"/> \$ 50,000 <input type="checkbox"/> \$ 175,000 |
| <input type="checkbox"/> \$ 75,000 <input type="checkbox"/> \$ 200,000 | <input type="checkbox"/> \$ 75,000 <input type="checkbox"/> \$ 200,000 |
| <input type="checkbox"/> \$ 100,000 <input type="checkbox"/> \$ 225,000 | <input type="checkbox"/> \$ 100,000 <input type="checkbox"/> \$ 225,000 |
| <input type="checkbox"/> \$ 125,000 | <input type="checkbox"/> \$ 125,000 |

***Please note that all changes requested above will become effective on the 1st of the month following receipt of a signed form.**

AUTHORIZATIONS & DECLARATIONS

- I AUTHORIZE:
- Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and
 - Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled.

When providing personal information for my spouse and/or dependants, I **confirm** that I am authorized to act on their behalf. I **agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original. I **certify** that the information given is true, correct and complete to the best of my knowledge.

Member's Signature _____

Date(y/m/d) _____

Protecting your personal information The administrator of your group benefits plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.