



Retiree Benefits Change Form

PR036/20

The information requested on this form is being collected pursuant to the Freedom of Information and Protection of Privacy (FOIP) Act, notably Sections 33, 34, 39 and 40, and is restricted to Division personnel responsible for administering Payroll and Benefits.

Surname:	Given:	Initial:	Retiree#:
Reason for Changes:			

Address/Phone CHANGES

Address:	City, Province:
Postal Code:	Telephone:

Dependent Coverage CHANGES

Spouse and dependents	Relationship to Employee	Birthdate YYYY/MM/DD	Student
Name: <input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: <input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: <input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: <input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No

Co-ordination of Benefits CHANGES

Applies to Health and/or Dental: <input type="checkbox"/> Health Care <input type="checkbox"/> Dental Care
Spouse's Employer:
Insurance Company:
Policy #:
Coverage Level: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family

Supplementary Health Care CHANGES

SINGLE <input type="checkbox"/> \$118.00/month	COUPLE <input type="checkbox"/> \$235.00/month	FAMILY <input type="checkbox"/> \$354.00/month
WAIVED <input type="checkbox"/> (attach letter from spouse's employer confirming coverage from spouse's employer)		

Dental Health Care CHANGES

Single <input type="checkbox"/> \$77.00/month	Couple <input type="checkbox"/> \$154.00/month	Family <input type="checkbox"/> \$231.00/month
WAIVED <input type="checkbox"/> (attach letter from spouse's employer confirming coverage)		Irrevocable Opt Out <input type="checkbox"/> ((no opting back in))

Life Insurance (\$25,000) and A.D.& D. (\$25,000) Cost per month \$2.40

REVOCABLE BENEFICIARY:		
Surname:	Given Name:	Relationship:
Phone:	Address:	

I hereby declare that I have read and understood the information contained on this form and that the use of personal information and the information I have provided is correct.	
SIGNATURE: _____	Date: _____