EMPLOYEE CHANGE REQUEST

For office use only

Effective Date	Certificate #

To be Completed by Employer (Please print clearly in INK)

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Employer Name			Employer Code
Employee Name			Certificate #
☐ Occupation Change	New Occupation		Effective Date (MM/DD/YYYY)
☐ Salary Change	Earnings $	☐ Annually ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Hourly	# hours/week
Effective Date of Salary Change (MM/DD/YYYY)			
Employer's Signature			Date (MM/DD/YYYY)

To be completed by the employee - Please print clearly in INK)

2

☐ Address Change	New Address	
☐ Name Change	From	Daytime Phone # ( )
	To	
	Reason for Change	
☐ New Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	Date of Change (MM/DD/YYYY)
	☐ Common Law (Date of Co-habitation - MM/DD-YYYY)	
☐ Add Benefits	☐ Health ☐ Dental Previously covered under spouse's plan? ☐ No ☐ Yes If Yes; Date spouse's coverage terminated (MM/DD/YYYY) ________/_________/____________	
☐ Add Dependent(s)	Please Complete Section 3	
☐ Waive Health and/or Dental Coverage	☐ Health ☐ Dental Spouse's Insurer's Name ________________________________	
	Effective Date of Change (MM/DD/YYYY)	
☐ Change Level of Coverage (Please Complete Section 3)	☐ Change from family to single coverage Reason:________________________________	Date of Change (MM/DD/YYYY)
	☐ Change from single to family coverage Reason:________________________________	Date of Change (MM/DD/YYYY)

List all your dependents affected by the change, including your spouse: (Please print clearly in INK)

3

	Date of Change MM/DD/YYYY	First Name & Initial (Last Name if Different)	Relationship	Birthdate MM/DD/YYYY	Status/Nonstatus	Gender
☐ Add ☐ Delete					☐ Status ☐ Non-Status	☐ M ☐ F
☐ Add ☐ Delete					☐ Status ☐ Non-Status	☐ M ☐ F
☐ Add ☐ Delete					☐ Status ☐ Non-Status	☐ M ☐ F

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Beneficiary Designation - Please print clearly in INK (crossed out or revised info must be initialled by employee)

First & Last Name	Middle Initial	Date of Birth (MM/DD/YYYY)	% of Benefit	Relationship

*Only whole percentages are accepted for the pension beneficiary proportion

☐ Additonal Beneficiaries

☐ Contingent Beneficiaries (Secondary beneficiary if the above Beneficiary is deceased)

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First & Last Name	Middle Initial	Date of Birth (MM/DD/YYYY)	% of Benefit	Relationship

*Only whole percentages are accepted for the pension beneficiary proportion

Trustee/Administrator Designation

If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Full Name ______________________ **Relationship** ______________________

If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator

Employee Signature (Please sign and date below)

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Authorization and Consent

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by MGI Financial Inc. and the insurance carriers of may group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and service to me and my employer, and to manage the organization's business

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand that the personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding MGI Financial Inc.'s Group Benefits privacy policy I can contact MGI Financial at 204-786-0324 or privacy@mgiwealth.com should I have questions as to the collection, use or disclosure of my personal information

I certify that all information contained herein is correct and hereby confirm the beneficiary designation and authorize payroll deductions, if required.

I understand the coverage will only be effective if this application is accepted by the insurance carrier and such coverage shall not be effective prior to the effective date as outlined in the agreement between the insurance carrier and my employer.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

Signature of Employee______________________________ **Date**______________________