

EMPLOYEE CHANGE REQUEST



For office use only Effective Date Certificate #

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

Employer Name ABC COMPANY		Employer Code 12345	
Employee Name SUSAN SMITH		Certificate # 12345	
<input checked="" type="checkbox"/> Occupation Change	New Occupation SERVICE REP.	Effective Date (MM/DD/YYYY) 10/01/2011	
<input checked="" type="checkbox"/> Salary Change	Earnings \$40,000	<input checked="" type="checkbox"/> Annually <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly	# hours/week 35
Effective Date of Salary Change (MM/DD/YYYY) 10/01/2011		<input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Hourly	
Employer's Signature J. Doe		Date (MM/DD/YYYY) 10/03/2011	

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

<input checked="" type="checkbox"/> Address Change	New Address 123 ANY STREET, WINNIPEG, MB, R2R 0A2		
<input checked="" type="checkbox"/> Name Change	From SUSAN SMITH	Daytime Phone # ()	
	To SUSAN JONES		
	Reason for Change MARRIAGE		
<input checked="" type="checkbox"/> New Marital Status	<input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed	Date of Change (MM/DD/YYYY) 10/01/2011	
	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
	<input type="checkbox"/> Common Law (Date of Co-habitation - MM/DD/YYYY)		
<input type="checkbox"/> Add Benefits	<input type="checkbox"/> Health <input type="checkbox"/> Dental	Previously covered under spouse's plan? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	If Yes; Date spouse's coverage terminated (MM/DD/YYYY) _____/_____/_____		
<input checked="" type="checkbox"/> Add Dependent(s)	Please Complete Section 3		
<input type="checkbox"/> Waive Health and/or Dental Coverage	<input type="checkbox"/> Health <input type="checkbox"/> Dental	Spouse's Insurer's Name _____	
	Effective Date of Change (MM/DD/YYYY)		
<input checked="" type="checkbox"/> Change Level of Coverage (Please Complete Section 3)	<input type="checkbox"/> Change from family to single coverage	Date of Change (MM/DD/YYYY)	
	<input checked="" type="checkbox"/> Change from single to family coverage	Date of Change (MM/DD/YYYY) 10/01/2011	
	Reason: MARRIAGE		

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

	Date of Change MM/DD/YYYY	First Name & Initial (Last Name if Different)	Relationship	Birthdate MM/DD/YYYY	Status/Nonstatus	Gender
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	10/01/2011	JOHN A.	SPOUSE	01/01/1960	<input checked="" type="checkbox"/> Status <input type="checkbox"/> Non-Status	<input checked="" type="checkbox"/> M <input type="checkbox"/> F
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	10/01/2011	JANE R. BROWN	STEP- DAUGHTER	01/01/1995	<input checked="" type="checkbox"/> Status <input type="checkbox"/> Non-Status	<input type="checkbox"/> M <input checked="" type="checkbox"/> F
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	10/01/2011	JOHNNY B.	STEP- SON	01/01/1996	<input checked="" type="checkbox"/> Status <input type="checkbox"/> Non-Status	<input checked="" type="checkbox"/> M <input type="checkbox"/> F

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

First & Last Name	Middle Initial	Date of Birth (MM/DD/YYYY)	% of Benefit	Relationship
JOHN JONES	A.	01/01/1960	100%	SPOUSE

*Only whole percentages are accepted for the pension beneficiary proportion

Additional Beneficiaries

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

First & Last Name	Middle Initial	Date of Birth (MM/DD/YYYY)	% of Benefit	Relationship
JANE BROWN	R.	01/01/1995	50%	STEP-DAUGHTER
JOHNNY JONES	B.	01/01/1996	50%	STEP-SON

*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.

TOM SMITH

BROTHER

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)

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 my 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 S. Jones

Date 10/04/2011