bclear benefits

Please mail original, signed copy to:

bClear benefits
Suite 120 – 4401 Still Creek Drive
Burnaby, BC V5C 6G9

Changes Form

Parts 1 and 7 must be completed for all changes. All changes should be submitted within 31 days of the date of the event.
—You can fax the form for immediate processing, but the original must follow.
—Keep a copy of this form with the plan member's personnel file.

REASON FOR COMPLETION:

- ☐ Terminate Plan Member (Parts 1 and 7)
- ☐ Change of Beneficiary Designation (Parts 1, 4 and 7)
- ☐ Change in Family Status (Parts 1, 2, 3 and 7)
- ☐ Change of Name (Parts 1, 5 and 7)
- ☐ Change to Spousal or Other Coverage (Parts 1, 3 and 7)
- ☐ Change of Mailing Address (Parts 1, 6 and 7)

Account/Billing #
- Atrium (44055) ☐
- Hour Bank (29243) ☐
- Hour Bank Plus (49243) ☐

Part 1: Employee Identification — PLEASE COMPLETE THIS SECTION

Employer Group Name _____ **Account/Billing #** _____ **Division # (if applicable)** _____ **Class (if applicable)** _____ **ID #** _____

Employee's Last Name _____ **First Name** _____ **Initial** _____ **SIN** _____ **Date of Termination** ____/____/____

Part 2: Change in Family Status (You may also wish to complete Part 4)

Change of coverage requested due to the following "life event":

Date of Event (M/D/Y)

☐ Marriage ☐ Divorce ☐ Separation ☐ Death ☐ Birth ☐ Cohabitation* ☐ Other (specify) _____ ____/____/____

*please state the start date of **Cohabitation** or **Other** change (requirement of 12 months of cohabitation)

Revised Extended Health Coverage ☐ Single ☐ Family **Revised Dental Coverage** ☐ Single ☐ Family

Add	Cancel	Dep. #	Dependent's Last Name	First Name	Initial	Birthdate (MM/DD/YY)	Relationship	Sex (M/F)	Provide name of school below if child is over 19 and studying full-time. If child is disabled and over 19 indicate nature of disability and attach details.
☐	☐								
☐	☐								

Part 3: Change of Spousal or Other Coverage

Change request for: ☐ Extended Health ☐ Dental coverage due to:

☐ Addition of spouse: Spouse has coverage on his/her employer's plan—**Date of Change should match the Date of Event in Part 2 (Complete COB, if applicable below)**

☐ Transferring to Spouse's plan—Date of Change should be the date the Spouse's plan went into effect ☐ Spouse's plan terminated—Date of Change should be the date the Spouse's plan terminated

Coordination of Benefits (COB) Information—Other Plan Details	Spouse's Carrier(s)	Spouse's Group#(s)	Spouse's Certificate ID#

Revised Extended Health Coverage ☐ Single ☐ Family ☐ Waive **Revised Dental Coverage** ☐ Single ☐ Family ☐ Waive

Part 4: Change of Beneficiary Designation

Last Name	First Name	Initial	Share of Proceeds (%)	Relationship to Employee	Name of Trustee for Beneficiaries Under the Age of Majority (19 in BC)	If a resident of Quebec* (please indicate)
						☐ Revocable ☐ Irrevocable
						☐ Revocable ☐ Irrevocable

To which benefit (s) does this change apply (if applicable to your group)? ☐ Basic Life ☐ Optional Life ☐ Voluntary AD&D (note beneficiary for basic, AD&D is same as for basic life insurance)

Part 5: Change of Name

☐ Employee ☐ Spouse ☐ Dependent Child

Previous Name _____ New Name _____

Part 6: Change in Mailing Address

Apt/Unit Number _____ **Mailing Address** _____ **Phone Number** _____

City _____ **Province** _____ **Postal Code** _____

Part 7: Authorization—I hereby confirm the above information is complete, true and correct. — PLEASE COMPLETE THIS SECTION

Where/If used, I authorize the use of my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.

Employee Signature _____ Date Signed (MM/DD/YY) ____/____/____

Authorized Signature _____ Date Signed (MM/DD/YY) ____/____/____