CANADA WEST CONSTRUCTION UNION

Benefit Plan Change Form

1 Policy/Administrative information

Company name (employer)		Policy number **34000**	Division number
Employee last name	Employee first name	Date of birth (dd –mmm- yyyy)	
BC PharmaCare number	Social insurance number (SIN)		

2 Changes requested (please check all that apply)

I wish to:

- ☐ Update my address **– please complete section 3**
- ☐ Advise of a name change **– please complete section 4**
- ☐ Update my privacy contacts **– please complete section 5**
- ☐ Change my beneficiary designation(s) **– please complete section 6**
- ☐ Change my coverage status (single or family) **– please complete section 7**
- ☐ Add dependent(s), cancel dependent(s) or correct dependent information **– please complete section 8**
- ☐ Advise of a change in my spouse's group insurance plan **– please complete section 9**

3 Update address and/or contact information

Main residence address (suite no. and street)	City	Postal code
Province of residence	Province of employment	Date of address change (dd –mmm- yyyy)

4 Advise of a name change

New last name	New first name(s)

Reason for change

☐ Marriage ☐ Correction ☐ Other (please specify) _____

5 Update my privacy contacts

	Name of individual	Relationship to you
☐ Add ☐ Remove		
☐ Add ☐ Remove		

6 Change beneficiary designation

Beneficiary last name	Beneficiary first name	Relationship to you	%
Beneficiary last name	Beneficiary first name	Relationship to you	%

Nomination of trustee for beneficiary under the legal age – please list a trustee below if your beneficiary is under the legal age

Trustee last name	Trustee first name	Relationship to employee

7 Change my coverage status

Current coverage	Requested coverage
☐ Single ☐ Family	☐ Single ☐ Family

Reason for change:

☐ Marriage	Date of marriage (dd –mmm- yyyy): ______________________________
☐ Divorce/Separation	Date of divorce/separation (dd –mmm- yyyy): ______________________________
☐ Cohabitation	Date of cohabitation (dd –mmm- yyyy): ______________________________
☐ Birth of child	Date of birth (dd –mmm- yyyy): ______________________________
☐ Termination of spouse's insurance	Date of termination (dd –mmm- yyyy): ______________________________
☐ Termination of dependent coverage	Date of termination (dd –mmm- yyyy): ______________________________
☐ Termination of dependent coverage	Reason: Date of termination (dd –mmm- yyyy):
☐ Other, please specify:	Effective date of change (dd –mmm- yyyy): ____________

8 Change dependent information

Spouse last name	Spouse first name	Date of birth (dd –mmm- yyyy)	Sex	Reason		
			☐ Male ☐ Female	☐ Add ☐ Cancel ☐ Correct		

Child last name	Child first name	Date of birth (dd –mmm- yyyy)	Sex	Student	Overage disabled	Reason
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Add ☐ Correct ☐ Cancel
Child last name	Child first name	Date of birth (dd –mmm- yyyy)	Sex	Student	Overage disabled	Reason
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Add ☐ Correct ☐ Cancel
Child last name	Child first name	Date of birth (dd –mmm- yyyy)	Sex	Student	Overage disabled	Reason
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Add ☐ Correct ☐ Cancel
Child last name	Child first name	Date of birth (dd –mmm- yyyy)	Sex	Student	Overage disabled	Reason
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Add ☐ Correct ☐ Cancel

9 Update spouse's insurance information

Specify your spouse's coverage	Name of insurer	Policy no.
Extended Health ☐ Single ☐ Family **Dental** ☐ Single ☐ Family		

10 Authorization and signature

Signature	Date (dd –mmm- yyyy)

Contact Us:
Phone: 1-844-293-2330
Email: benefits-admin@cwcu.ca

Mail Completed Form To:
#211- 3823 Henning Drive,
Burnaby, BC V5C 6P3