



Unistar Special Risks Inc.
 850, 10655 Southport Road SW
 Calgary, Alberta T2W 4Y1
 Phone (403) 297-0250
 Toll Free: (800) 292-9066
 Fax: (403) 269-3939

**LIFESTYLE
 COVERAGE/CHANGE
 FORM**

These sections are to be completed by the Plan Administrator. Please print clearly IN INK.

1. General Information:

Employer: _____ Policy No.: _____ Div. No.: _____
 Employee: _____ ID #: _____
 (last name) (first name) (initial) SIN #: _____
 Province of residence: _____ Province of employment: _____

2. Reinstatement:

Date of Return to Work: Month: _____ Day: _____ Year: _____
 Reason for Reinstatement: Return from Leave of Absence Return from Maternity leave Education Leave
 Return from Lay-off Returning Employee (rehire)

These sections are to be completed by the Employee. Please print clearly IN INK.

3. Refusal of Benefits:

Health, Dental and/or Vision coverage may **only** be removed if you have duplicate coverage through your spouse's employer plan, or other government program.

I understand the plan of group benefits offered to me, but I decline to participate in:

Healthcare for myself and my dependents my dependents only
 Dentalcare for myself and my dependents my dependents only

FOR COORDINATION OF BENEFITS:

Spousal Insurer's name: _____ Policy #: _____

What group benefits coverage does your spouse/common law spouse have through an employer?

HEALTHCARE Single Family Waived None
 DENTALCARE Single Family Waived None

If you lose spousal coverage, you must apply for coverage within 31 days of the loss of such coverage. If you do not apply within the 31 days, you may be required to provide proof of your (and your spouse's) insurability before coverage can begin. If you are approved, your Dental benefits (if any) may be restricted.

4. Addition of Benefits:

If your spouse has lost group benefits coverage through his/her employer, or through any government program, you may apply to be enrolled for group coverage under this plan.

Effective Date of Loss of Coverage: Month: _____ Day: _____ Year: _____

Please indicate the benefit(s) no longer covered under the spousal or government plan. Healthcare Dental care

5. Dependent Information:

This section must be completed if you are adding or deleting a dependent, or updating dependent information. If more space is necessary, please attach a separate sheet of paper with the information.

Effective Date of Change: Month _____ Day: _____ Year: _____

Reason: Birth of Child Cohabitation Marriage Divorce/Legal Separation
 Other (please specify): _____

Change from: Single Family To: Single Family

Date of Cohabitation or Marriage: Month: _____ Day: _____ Year: _____

Spouse/Common Law Spouse Information:

Add Change Delete

(last name) (first name) (initial)

Female Male

FOR COORDINATION OF BENEFITS: What group benefits coverage does your spouse/common law spouse have through an employer or government program?

Health Single Family Waived None

Dental Single Family Waived None

Spousal Insurer's Name: _____ Policy No.: _____

Dependent Information:

Add	Change	Delete	Last Name, First Name & Initial	Date of Birth (mm/dd/yyyy)	Gender		Full Time Student		Disabled Dependent	
					Male	Female	[Yes	No]	[Yes	No]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Unistar Special Risks Inc.
 850, 10655 Southport Road SW
 Calgary, Alberta T2W 4Y1
 Phone (403) 297-0250
 Toll Free: (800) 292-9066
 Fax: (403) 269-3939

**LIFESTYLE
 COVERAGE/CHANGE
 FORM**

To be completed by the plan administrator.

Policy No.: _____ Employee Name: _____ ID No.: _____

Overage Student Information (for any full time students over age 21):

Name of Student:	School Attended (University or College)	Enrolled From: (mm/dd/yyyy)	Enrolled To: (mm/dd/yyyy)

6. **Employee Name Change:** From: _____ To: _____

7. **Beneficiary Designation Changes:** The original copy of this form will be required for a Life claim. Please print clearly IN INK.

I hereby make the following change(s) to my previous beneficiary appointment:

<u>Beneficiary's Name(s)</u> (last name, first name & initial)	<u>Date of Birth</u> (MM/DD/YYYY)	<u>Percent Allocated</u>	<u>Relationship to Employee</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby make the above beneficiary designation: Revocable Irrevocable

You may change a revocable beneficiary at any time. You may not change an irrevocable beneficiary without the written consent of the irrevocable beneficiary.

Current Beneficiary Name Change:

From: _____ To: _____
 (last name) (first name) (initial) (last name) (first name) (initial)
 Relationship to employee: _____ Date of Birth (MM/DD/YYYY): _____

8. **Opting Out of All Group Benefits: (For non-compulsory plans only)**

- I understand the group benefits plan offered to me, but I decline to participate. If at any time in the future I wish to join the group benefits plan, I and my dependents will have to provide proof of insurability acceptable to Unigroup Inc. in order to be covered. If approved, I understand that my Dental benefits (if any) may be restricted.

Effective Date: _____

 (Employee's signature)

9. **Authorizations & Declarations:**

I certify that the information given is true and complete to the best of my knowledge. If applying for benefits for my spouse/common law spouse and/or dependents, I am authorized to release information concerning my spouse/common law spouse and my dependents for the purpose of determining their eligibility for benefits.

If my social insurance number is used as my certificate number, I authorize use for the identification and administration of my group benefits. I authorize Unigroup Inc. to make any and all inquiries, or to exchange information, relating to group benefits claims and administration on behalf of myself and my dependents.

For Quebec applicants: I request that this form be in English. Je demande que ce formulaire me soit remis en anglais.

Employee's signature : _____ Date : _____