Plan member change request

people CORPORATION®
Experience the Benefits of People

Plan member: Complete all applicable sections, sign, and submit to your plan administrator.
Plan administrator: Review and sign this form and submit to People Corporation.
Submit via email: adminsupport@peoplecorporation.com
Submit via mail: 1403 Kenaston Blvd., Winnipeg MB R3P 2T5
Submit via fax: 204-488-6008 **Claim inquiries:** 1-800-875-7982

Plan member information

Division name: _____

Plan member name: _____ Certificate #: _____

Plan member changes

☐ Name change

Change effective date (DD/MM/YYYY): _____ Reason for change: _____

Prior last name: _____ Prior first name: _____

New last name: _____ New first name: _____

☐ Address change

Change effective date (DD/MM/YYYY): _____

Prior address: _____

New address: _____

☐ Marital status change

☐ Single ☐ Married/Common-law ☐ Divorced ☐ Separated ☐ Widowed

If common-law, date of co-habitation (DD/MM/YYYY): _____ Change effective date (DD/MM/YYYY): _____

Coverage changes

☐ Class change

Change effective date (DD/MM/YYYY): _____

Current class: _____ New class: _____

Reason for change: _____

☐ Coordination of benefits update

Select and complete all that apply:

☐ I (and/or) ☐ Dependants have **obtained** coverage through another: ☐ Health plan ☐ Dental plan

Name of insured: _____

Name of insurance company(ies): _____

Health plan #: _____ Health plan termination date (DD/MM/YYYY): _____

Dental plan #: _____ Dental plan termination date (DD/MM/YYYY): _____

☐ I (and/or) ☐ Dependants have **lost** coverage through another: ☐ Health plan ☐ Dental plan

Name of insured: _____

Name of insurance company(ies): _____

Health plan #: _____ Health plan termination date (DD/MM/YYYY): _____

Dental plan #: _____ Dental plan termination date (DD/MM/YYYY): _____

☐ **Waive coverage**

You can waive coverage for yourself and/or your dependants if they are covered for similar benefits under another insurance plan. Coordination of benefits section must also be completed. **Select all that apply.**

I wish to waive **Health** coverage for: ☐ Myself ☐ My dependants
I wish to waive **Dental** coverage for: ☐ Myself ☐ My dependants

☐ **Add coverage**

You can add coverage for yourself and/or your dependants if they have lost coverage for similar benefits under another insurance plan. Coordination of benefits section must be completed. **Select all that apply.**

I wish to add **Health** coverage for: ☐ Myself ☐ My dependants

I wish to add **Dental** coverage for: ☐ Myself ☐ My dependants

Reason for addition of coverage (select all that apply):

☐ I lost coverage under another insurance plan ☐ My dependants lost coverage under another insurance plan

☐ Other (provide explanation): _____

If "other", please note that coverage may be subject to approval, based on first satisfying medical requirements set out by the insuring company(ies) and People Corporation. A separate application, including medical evidence, may be required. Any coverage approved may be subject to certain restrictions.

☐ **Terminate coverage for dependants**

☐ I wish to terminate coverage for certain dependants (complete Dependant changes section)

☐ I wish to terminate coverage for all dependants (only elect if you no longer have any dependants)

Change effective date (DD/MM/YYYY): _____ Reason for termination: _____

☐ **Plan member termination** (for plan administrator use only)

Last date worked (DD/MM/YYYY): _____

Reason for termination: ☐ No longer employed ☐ Laid-off
Leave of absence: ☐ Medical ☐ Personal
Legislative leave: ☐ Maternity ☐ Parental ☐ Compassionate care

☐ Other: _____

Dependant changes

Complete this section when adding or removing dependant(s) or updating existing dependant information.

Please note that any eligible dependant added will automatically be enrolled in Dependant Life coverage if such coverage is offered under the group benefits plan.

Please complete and submit an over age dependant application (M1004) along with this form if a dependent child is over age and attending College or University, or if you are enrolling them as an over age disabled dependant.

Change codes: **A** – Add **B** – Remove **C** - Change

Change Code	Effective date of change (DD/MM/YYYY)	Last name	First name	Date of birth (DD/MM/YYYY)	Sex (M/F)	Relation to plan member	Over age dependant	Status Indian
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No

Plan member attestation and signature

I _____ attest that the information provided is true and accurate. If applying for benefits for my Spouse and Dependants, I am authorized to release information concerning my Spouse and my Dependants for the purpose of determining eligibility for benefits. I acknowledge that I have the right to request access to the Personal Information in my file and, where appropriate, to have inaccurate information corrected. I acknowledge that a photocopy or electronic copy of this authorization will be valid as the original.

Plan member signature: _____ Date signed: _____

Plan administrator attestation and signature

I _____ confirm that the information provided is true and accurate.

Plan administrator signature: _____ Date signed: _____

All changes are subject to the terms of the Group Insurance Contract(s) and any applicable legislation.