Salary change request

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Experience the Benefits of People

Group no. _____ **Division no.** _____ **Division name:** _____

Certificate no.	**Plan member name**	**New monthly salary**	**Effective date of change** DD / MM / YYYY

Plan administrator signature		Date signed DD / MM / YYYY	

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

Reminder: Disability insurance is based on declared monthly income. Confirmation of income, deemed satisfactory by the insurer, will be required at the time of claim. This usually consists of the last two T1 General Income Tax returns. Premium refunds will not be issued for any discrepancies.