04/2021

Health Benefits Trust Fund (HBTF) Plan

Request for Change Form

- Print clearly, in ink, and complete both pages of this form.
- Complete SECTIONS 1 and 9 for ALL changes and any other sections that are applicable.
- Forward the completed form to Doctors of BC at the address below, via fax at (604) 604-638-2909 or email to insurance@doctorsofbc.ca.
- Retain a copy for your files.

At Doctors of BC, we know that confidentiality of personal information is important. Go to https://www.doctorsofbc.ca/privacy-policy to view Doctors of BC's Privacy Policy. By participating in this Plan, you authorize Doctors of BC and its insurers to use the information collected on this form for benefits administration.

1. General Information

MUST BE COMPLETED

Business ID

Member ID

Insured Member's name: last name | first name | initial

2. Name Change

Complete this section for yourself or your dependents.

Former name: last name | first name | initial

New name: last name | first name | initial

3. Group Life / AD&D

Medical Office Staff only. Satisfactory proof of good health is required to increase coverage.

Please select the Group Life/AD&D benefit you wish to apply/reapply for: ☐ $20,000 ☐ $50,000

Please confirm the Beneficiary Designation below:

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary. If no beneficiary is designated, benefits will be payable to the Estate.

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Complete this section if a beneficiary named on this form is a minor. If so, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Primary Beneficiary

First Name	Last Name	Gender	Relationship	Amount %	Age (if Uunder 18)
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			

Secondary Beneficiary

First Name	Last Name	Gender	Relationship	Amount %	Age (if under 18)
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			

Trustee

First Name	Last Name	Gender	Relationship
		☐ Male ☐ Female	

4. Long Term Disability

Medical Office Staff only

Satisfactory proof of good health is required to increase coverage.

Long Term Disability (check one only):

☐ I was previously declined for Long Term Disability (LTD) coverage and wish to reapply for the amount indicated below.

☐ I am currently insured for $ _____ of monthly LTD benefit and wish to increase/ decrease my coverage as indicated below.

Please confirm your current monthly earnings: $ _____

Taxable monthly benefit: (check one only)

☐ $ 1,000 ☐ $ 1,200 ☐ $ 1,500

☐ $ 2,000 ☐ $ 2,500

Please note the amount selected should not exceed **85%** of gross monthly earnings.

T 604 638 2908
F 604 638 2909
TF 1 800 665 2262

115—1665 West Broadway
Vancouver BC V6J 5A4

doctorsofbc.ca

5. Refusal of Extended Health Care and Dental Care Benefits

Complete this section if you wish to refuse Extended Health Care and Dental Care benefits for yourself and/or your eligible dependent(s). **This will be allowed only if similar benefits are currently in force under your spouse's group policy.**

NOTE: Health and/or Dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer. I understand the plan of group benefits offered to me, but I decline to participate in:

Check one only:

Healthcare for: ☐ Myself and my dependent(s) (if any) ☐ My dependent(s) ONLY
Dentalcare for ☐ Myself and my dependent(s) (if any) ☐ My dependent(s) ONLY

Current Carrier | Policy Number | mm dd yyyy

*I understand that if my and/or my dependent(s)' coverage terminates under the policy indicated above, I may apply for coverage under this Plan within 90 days of loss of coverage without proof of good health.

6. Life Events- Cancellation

Complete this section to cancel all coverage for dependents who are currently covered but are no longer eligible (e.g. Child age 22 or over leaving school, divorce, separation, etc.)

I wish to cancel all coverage for the following dependent(s) who are no longer eligible for coverage:

First Name	Reason For Cancellation

7. Life Events–Addition

Complete this section to add new dependents or to add coverage for yourself and/or dependents which was previously refused. Provide the name(s) of your dependents in Section 7. Applicants must be covered under a Provincial Health Care plan to be eligible.

Satisfactory proof of good health for you and/or your dependent(s) may be required.

Addition of Extended Health and Dental Care

I wish to ADD Extended Health and Dental Care for: (Check one only)

☐ Myself and my dependents (if any)

☐ My dependent(s) ONLY (I am already covered)

Event Date (mm dd yyyy)

* If Other, please give details. If necessary, attach a separate sheet.

Reason for Addition: (Check one event only, provide Event Date above)

☐ Birth/Adoption of child(ren) ☐ Spouse's coverage under another plan terminated

☐ Marriage ☐ Return to school ☐ Other*

☐ Common-law relationship for at least one year (**Event Date is date cohabitation began**)

8. Dependent Information

Complete this section only when you are changing information pertaining to dependents that have previously been enrolled OR when you are adding a dependent.

An "eligible dependent" is defined as any person who is:

- Your legal spouse, or person with whom you have lived for one year and have publicly represented as your spouse.
- Your unmarried dependent child(ren) under age 22, or under age 25 if attending an accredited educational institute, college or university on a full-time basis, relying upon you for support and maintenance.
- Special circumstances such as children over the age of 22 with a mental or physical handicap, conditions of separation or maintenance agreements (court orders) may require additional documentation to be filed with Doctors of BC and/or the Insurer, and be subject to approval.

First Name	Initial	Last Name	Gender	Relationship to you (spouse/son/daughter)	Date of Birth mm dd yyyy	If child is age 22 or over, check box *
spouse			☐ Male ☐ Female			N/A
child			☐ Male ☐ Female			☐
child			☐ Male ☐ Female			☐
child			☐ Male ☐ Female			☐
child			☐ Male ☐ Female			☐

* If any of the above dependent child(ren) are full-time students age 22 or over but under the age of 25, please indicate below the name of the student and the college or university attended in the spaces provided. If a dependent child is over the age of 22, mentally or physically disabled and dependent upon you for support and maintenance, please indicate the nature of disability below.

First Name	Name of College/University or nature of disability

9. Insured Member's Signature

MUST BE COMPLETED

I certify that the information in this form is true and complete, to the best of my knowledge.

By participating in this Plan, I authorize the following:

Canada Life Assurance Company ("Canada Life"), its agents and service providers its reinsurers and their service providers to collect, use and disclose relevant information about me to underwrite, administer and adjudicate claims, my plan sponsor and its agents and Doctors of BC to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required; Canada Life, its agents and service providers and my plan sponsor and its agents to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and purposes of continuing administration of the plan.

I certify the spouse named above (if applicable) is my legal spouse or my common-law or same-sex partner with whom I have been residing for a minimum of 12 months and have publicly represented as my spouse.

Insured Member's Signature — mm dd yyyy

10. Employer/Physician's Signature

Required if an employee is applying for an increase in coverage or is adding dependents.

Employer/Physician's Signature — mm dd yyyy