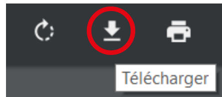
# Steps to complete the form

1

Click on the download button for save the form on your computer.




2

Fill in the fields of the form and save your information before submitting it to us.

# UV INSURANCE

# CHANGE REQUEST - EMPLOYEE
## GROUP INSURANCE

## EMPLOYEE'S INFORMATION

| NAME OF THE EMPLOYER | GROUP NO. | DIVISION NO. | CLASSE | EMPLOYEE NUMBER ID |
|---|---|---|---|---|
| | | | | |

| EMPLOYEE LAST NAME | FIRST NAME | CERTIFICATE OF U.L. MUTUAL |
|---|---|---|
| | | |

## ☐ CHANGE OF COVERAGE IF YOU HAVE CHOOSE FAMILY COVERAGE, PLEASE COMPLETE THE « DEPENDANTS » SECTION

**NEW COVERAGE :** ☐ SINGLE WITH DEPENDANT LIFE ☐ SINGLE ☐ COUPLE ☐ FAMILY ☐ SINGLE PARENT ☐ WAIVED ☐ OTHER ____________

**REASON:** ☐ BIRTH ☐ ADOPTION ☐ CIVIL UNION ☐ MARRIAGE BEGINNING OF COHABITATION Y M D ☐ DIVORCE ☐ END OF COHABITATION ☐ LOSS OF SPOUSE COVERAGE EFFECTIVE DATE OF CHANGE Y M D

### ☐ DEPENDANTS

| CHANGE | FAMILY NAME | FIRST NAME | SEX | DATE OF BIRTH | FULL-TIME STUDENT AGE 21 OR MORE | DISABLED DEPENDANT |
|---|---|---|---|---|---|---|
| ☐ ADD SPOUSE ☐ DELETE SPOUSE ☐ CHANGE | | | ☐ M ☐ F | Y M D | | |
| ☐ ADD CHILD ☐ DELETE CHILD ☐ CHANGE | | | ☐ M ☐ F | Y M D | YES ☐ NO ☐ | YES ☐ NO ☐ |
| ☐ ADD CHILD ☐ DELETE CHILD ☐ CHANGE | | | ☐ M ☐ F | Y M D | YES ☐ NO ☐ | YES ☐ NO ☐ |
| ☐ ADD CHILD ☐ DELETE CHILD ☐ CHANGE | | | ☐ M ☐ F | Y M D | YES ☐ NO ☐ | YES ☐ NO ☐ |

* PROOF OF FULL-TIME STUDY REQUIRED
** PROOF REQUIRED

### ☐ REFUSAL OF BENEFITS

WAIVE MYSELF AND MY DEPENDANTS : ☐ HEALTH CARE ☐ DENTAL CARE

WAIVE MY DEPENDANTS ONLY : ☐ HEALTH CARE ☐ DENTAL CARE

SPOUSAL NAME : ____________ SPOUSAL PLAN NUMBER : ____________ SPOUSAL CERTIFICATE NUMBER ____________

SPOUSAL INSURER NAME : ____________ EFFECTIVE DATE OF CHANGE : Y M D

### ☐ REINSTATEMENT OF BENEFITS

EFFECTIVE DATE OF LOSS OF COVERAGE THROUGH SPOUSAL PLAN : Y M D

REASON OF LOSS OF COVERAGE THROUGH SPOUSAL PLAN :

### REQUIRED SIGNATURES

DATE ____________ EMPLOYEE SIGNATURE ____________

DATE ____________ PLAN ADMINISTRATOR SIGNATURE ____________

## ☐ BENEFICIARY DESIGNATION

**NOTE: WHERE QUEBEC LAW APPLIES AND YOU HAVE DESIGNATED YOUR MARRIED SPOUSE OR CIVIL UNION SPOUSE AS BENEFICIARY, THE DESIGNATION WILL BE IRREVOCABLE UNLESS YOU CHECK THE BOX MARKED « REVOCABLE » BELOW.**

| | LAST NAME : | FIRST NAME : | RELATIONSHIP | |
|---|---|---|---|---|
| **ACTUAL BENEFICIARY** | | | | ☐ REVOCABLE ☐ IRREVOCABLE |
| **NEW BENEFICIARY** | | | | ☐ REVOCABLE ☐ IRREVOCABLE |

### FILL THIS SECTION ONLY IF THE CURRENT BENEFICIARY IS IRREVOCABLE

AS THE CURRENT IRREVOCABLE BENEFICIARY OF THE ABOVE MENTIONED POLICY, I HEREBY AGREE TO BE REVOKED AND I GIVE UP ALL MY RIGHTS AND PRIVILEGES UNDER THE TERMES OF THIS POLICY.

DATE ____________ CURRENT BENEFICIARY SIGNATURE ____________ WITNESS SIGNATURE ____________

### EMPLOYEE SIGNATURE

I HEREBY REVOKE ALL BENEFICIARY DESIGNATIONS MENTIONED ABOVE ET DESIGNATE THE FOLLOWING AS BENEFICIARY

DATE ____________ EMPLOYEE SIGNATURE ____________ WITNESS SIGNATURE ____________

## ☐ CHANGE OF ADDRESS (NEW ADDRESS)

| ADDRESS | CITY | PROVINCE | POSTAL CODE |
|---|---|---|---|
| | | | |

UV INSURANCE

# CHANGE REQUEST – EMPLOYER
## GROUP INSURANCE

### EMPLOYEE'S INFORMATION

| EMPLOYER'S NAME | GROUP NO. | DIVISION NO. | CLASSE | EMPLOYEE'S NUMBER ID |
|---|---|---|---|---|
| | | | | |

| EMPLOYEE'S LAST NAME | FIRST NAME | CERTIFICATE OF U.L. MUTUAL |
|---|---|---|
| | | |

### SALARY CHANGE

NEW SALARY : ________________$

DATE OF CHANGE Y M D

☐ ANNUAL ☐ WEEKLY ☐ HOURLY RATES

NUMBER OF HOURS PER WEEK : ____________________

### CHANGE OF CLASS OR DIVISION

☐ CHANGE OF CLASS NEW CLASS _____________

☐ CHANGE OF DIVISION NEW DIVISION _____________

DATE OF CHANGE Y M D

### NOTICE OF ABSENCE OF WORK

☐ TEMPORARY LAYOFF

☐ LEAVE WITHOUT PAY

☐ MATERNITY LEAVE

☐ PARENTAL LEAVE

DATE OF DEPARTURE Y M D

☐ OTHER ________________________

EXPECTED DATE OF RETURN Y M D

### NOTICE OF RETURN TO WORK

NEW SALARY : ________________$

DATE OF RETURN TO WORK Y M D

☐ ANNUAL ☐ WEEKLY ☐ HOURLY RATES

NUMBER OF HOURS PER WEEK : ____________________

IS THE EMPLOYEE RETURNED TO HIS OWN OCCUPATION :

☐ YES, FULL-TIME

☐ NO, PLEASE EXPLAIN

☐ YES PART-TIME / NUMBER OF HOURS PER WEEK ________

PLEASE EXPLAIN :

_____________________________________________ _____________________________________________

_____________________________________________ _____________________________________________

### TERMINAISON

☐ WORK TERMINATION

☐ DEATH

☐ RETIREMENT

☐ ___________________________

DATE OF TERMINAISON Y M D

### COMMENTS

### SIGNATURE

DATE

SIGNATURE OF THE POLICY ADMINISTRATOR



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