1117

Health Benefits Trust Fund (HBTF) Plan

Request for Change Form

doctors of bc
British Columbia Medical Association

- 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) 604-638-2908 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 contact an HBTF Plan Administrator at Doctors of BC to update your beneficiary designation.

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.

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.

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.**

I refuse Extended Health Care and Dental Care benefits as I and/or my dependents are insured under my spouse's group policy.

I understand that if my and/or my dependent(s)' coverage terminates under the policy indicated below, I may apply for coverage under this Plan within 31 days of loss of coverage without proof of good health.

For: (check one only):

☐ Myself and my dependent(s) (if any)
☐ My dependent(s) ONLY

Current Carrier

Policy Number

Effective Date of Coverage mm dd yyyy

6. Life Events- Cancellation

Complete this section to cancel all coverage for dependents who are currently covered but are no longer eligible (eg. 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

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

115—1665 West Broadway
Vancouver BC V6J 5A4

doctorsofbc.ca

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.

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)

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

☐ 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**)

Event Date mm dd yyyy

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

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

* 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 particiating in this Plan, I authorize the following:

Great-West Life Assurance Company ("Great-West 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; Great-West 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