Grandeur Group Benefits

GROUP CHANGE FORM

EMPLOYMENT INFORMATION [TO BE COMPLETED BY YOUR PLAN ADMINISTRATOR] – COMPLETE ALL SECTIONS

GROUP NAME [EMPLOYER]	DIVISON	CLASS	CLIENT ID

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	Gender ☐ Male ☐ Female

EFFECTIVE DATE [MM/DD/YYYY]	ANNUAL SALARY	NUMBER OF HRS WORKED PER WEEK

REQUESTED CHANGES [TO BE COMPLETED BY PLAN ADMINISTRATOR] EFFECTIVE DATE OF CHANGES: ______________________

☐ NAME CHANGE	☐ ADDRESS CHANGE	
☐ Termination [Last Day Actively at Work]	☐ Salary Change [New Salary]	Salary Type: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annual
☐ CLASS CHANGE [NEW CLASS]	☐ DIVISION CHANGE [NEW DIVISION]	
☐ ADD SPOUSE/DEPENDENT	☐ REMOVE SPOUSE/DEPENDENT	

If adding a spouse please indicate what coverage spouse has through his/her employer:
Health: ☐ Single ☐ Couple ☐ Family ☐ Waived ☐ None
Dental: ☐ Single ☐ Couple ☐ Family ☐ Waived ☐ None

RELATIONSHIP	LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH MM/DD/YYYY	STUDENT	DISABLED DEPENDENT
SPOUSE			☐ MALE ☐ FEMALE			☐ Yes ☐ No
CHILD			☐ MALE ☐ FEMALE			☐ Yes ☐ No
CHILD			☐ MALE ☐ FEMALE			☐ Yes ☐ No
CHILD			☐ MALE ☐ FEMALE			☐ Yes ☐ No
CHILD			☐ MALE ☐ FEMALE			☐ Yes ☐ No

☐ **BENEFICIARY CHANGE:**

LAST NAME	FIRST NAME	RELATIONSHIP	REVOCABLE OR IRREVOCABLE	%

If you name an irrevocable beneficiary and wish to change it at a later date, the current beneficiary would be required to approve the change.

TRUSTEE DESIGNATION: This section is to be completed only if the beneficiary designated above is under the age of majority
(Trustee to receive any amount due to any beneficiary under the age of 18)

TRUSTEE NAME	RELATIONSHIP

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☐ **COVERAGE CHANGE:** **EFFECTIVE DATE OF CHANGE:** ________________________

Health: ☐ Single ☐ Couple ☐ Family ☐ Waive	**REASON FOR CHANGE**
Dental: ☐ Single ☐ Couple ☐ Family ☐ Waive	**REASON FOR CHANGE**

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another Group Insurance Plan you may opt out coverage by choosing the applicable box for each benefit.

I refuse coverage for myself, my spouse and my dependen	**☐ Extended Health Coverage**	**☐ Dental Coverage**
I refuse coverage for my spouse and my dependents	**☐ Extended Health Coverage**	**☐ Dental Coverage**

PLEASE PROVIDE THE DETAILS OF SPOUSE'S COVERAGE BELOW

Extended Health Coverage	**☐ Single ☐ Couple ☐ Family ☐ Waived ☐ None**	**Name of Insurance Co:**
Dental Coverage	**☐ Single ☐ Couple ☐ Family ☐ Waived ☐ None**	**Spouse's Employer:**

DECLARATION & AUTHORIZATION

I declare that the information provided above is accurate and true, and hereby authorize the Plan Administrator to use this information to administer the Group Benefits; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plans and prepare reports. I understand that this information will only be provided to those insurers affiliated with the Plan Administrator and acknowledge that I have obtained the consent of this Employee and Spouse/Partner to provide this information

Signature: **Date:**

PRIVACY & CONFIDENTIALLY

We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to *the* Plan Administrator*,* the information provided varies based on the relationship of the person making the inquire to the insured (e.g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only the information pertaining to the specific claim or treatment in question is shared.

EMPLOYER AUTHORIZATION

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Signature: **Date:**