Benefit Change Form

TRIO, 460 Torbay Road
St. John's, NL A1A 5J3

1. TO BE COMPLETED BY EMPLOYER (PLEASE PRINT) AND MAIL TO MARY GALWAY AT THE ABOVE ADDRESS OR FAX TO 1.888.584.6789

Member/Employee ______________________________ **SIN** ____________________
First Name(s) Last Name

Municipality ____________________ **Division** __________

2. Type of Change | **Effective Date of Change** ____ / ____ / ____ (DAY / MON / YR)

☐ Annual Salary ☐ Dependent ☐ Address / Telephone ☐ Marital Status
☐ Name Change ☐ Employment Type ☐ Benefit Change ☐ Other __________
☐ Beneficiary ☐ Termination of Member

3. New Employment Type (Class)

☐ Full Time (A) ☐ Part Time (C) ☐ Seasonal (B) ☐ Elected Member (D)
☐ Early Retirees (E) ☐ Over 65 Retirees ☐ Other Class ____________________
☐ Annual Earnings:$ __________ Earnings per: ☐ Hour $______ ☐ W eek $______ ☐ Month $______

4. Dependent(s)

		Birth Date			Sex	Children Status	
		Day	Mon	Yr	M/F	if over age 21 **S** = Student **D** = Disabled	**A**-Add **C**-Change **T**-Terminated
Spouse							
Dependent Children							

5. New Member/Employee Address

Street / P.O. Box		
City / Town		
Province		
Postal Code		Telephone

6. Benefits

Health	Effective Date (DD/MM/YY)	☐ Single ☐ *Couple ☐ Family	*Couple coverage only available to Small Town Plans
Dental	Effective Date (DD/MM/YY)	☐ Single ☐ *Couple ☐ Family	

7. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

BENEFICIARY DESIGNATION

Applies to Basic Life, Basic AD&D as well as any Optional Life and Optional AD&D, unless otherwise stated.

I name the following Beneficiary and reserve the right to change or cancel this at a later date

______________________ ______________ Date of Birth ____ / ____ / ____
First Name(s) Last Name Relationship DAY MON YR

If Beneficiary is under 18, please name Trustee. ______________________________
First Name(s) Last Name

In the event that my Beneficiary predeceases me, the following Contingent Beneficiary shall be entitled to the benefits:

Name: ______________________________ Date of Birth ____ / ____ / ____
DAY MON YR

X Signature of Insured ______________________ **Date** ____ / ____ / ____
DAY MON YR