Application for Change

Plan Member Information

Municipality Name	Plan Member/Employee Name

Termination of All Coverage

Reason For Termination	Date Last Worked (yy/mm/dd)

If employee is retiring, please offer the AMM Retiree Plan as soon as possible. Employee must apply within 31 days of retirement.

Name Change

Employee's Name From	Employee's Name To

Request must be completed within 31 days of marriage or divorce.

Change of Coverage Designation

Change to Family Coverage ❑ **Yes**

Please complete one of the following:

1. Change due to ❑ Marriage ❑ 12 Months Co-habitation	Date of Marriage/Co-habitation (yy/mm/dd)	Spouse Name		Spouse's Date of Birth (yy/mm/dd)
2. Change due to termination of spouse's insurance plan **Confirmation required, i.e. employee's letter to insurance company or letter from insurance company.**	Date of Termination of Spouse's Plan (yy/mm/dd)	Spouse Name		Spouse's Date of Birth (yy/mm/dd)
3. Change due to addition of a dependent child	Reason for Addition of Dependent Child	Child's Name	Sex ❑ M ❑ F	Child's Date of Birth (yy/mm/dd)
	Reason for Addition of Dependent Child	Child's Name	Sex ❑ M ❑ F	Child's Date of Birth (yy/mm/dd)

Family coverage must be applied for within 31 days from the date of Change or Medical Evidence will be required.

Change to Single Coverage ❑ **Yes**

Please complete one of the following:

1. Change due to spouse obtaining insurance plan	Spouse's Coverage Includes ❑ Health ❑ Dental	Effective Date of Spouse's Coverage (yy/mm/dd)	Spouse's Coverage is ❑ Single ❑ Family
	Spouse's Insurance Carrier	Policy Number	
2. Change due to separation, divorce or death of spouse	Date of Separation/Divorce (yy/mm/dd)	Date of Death (yy/mm/dd)	

Waive Health & Dental Coverage ❑ **Yes**

Waiver of Health and Dental Benefits are only permitted if similar coverage is provided through your spouse's plan.	Spouse's Coverage Includes ❑ Health ❑ Dental	Effective Date of Spouse's Family Coverage (yy/mm/dd)
	Spouse's Insurance Carrier	Policy Number

Certification and Authorization

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete. At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to: • our employees and representatives in the performance of their jobs; • persons to whom you have granted access in writing; and • persons authorized by law. You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information. Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group Insurance Solutions' commitment to privacy and security refer to our web site: www.westerngis.ca

Employer Signature	Employer Date Signed (yy/mm/dd)

Complete and send to:
Western Financial Group Insurance Solutions
777 Portage Avenue, Winnipeg, MB R3G 0N3
Toll Free: 1-800-665-8990

Western Financial Group (Network) Inc.
2000-AMME/05-2010