BCCA Employee Benefit Trust Employee Change Form

Please mail completed original to
BCCA Employee Benefit Trust
120-4401 Still Creek Drive Burnaby BC V5C 6G9
604-683-7353 1-800-665-1077
hr@bccabenefits.ca fax: 1-604-299-2982

Name of Employer_____

Policy No._____ **Group Code** (Internal use) _____

Please Print Clearly

Employee Information

Last Name	First Name	SIN or ID Number

Personal Change Information

☐ **Name Change**	**Former Name**		**New Name**			
☐ **New Address**	**Street Address**		**City**		**Province**	**Postal Code**

☐ **Beneficiary Change**	**Last Name**	**First Name**	**Share of Proceeds**	**Relationship**	**Full Legal Name of Trustee** Required for beneficiaries under the age of majority	**Residents of Quebec:**
			%			☐ **Revocable**
			%			☐ **Revocable**

Add Dependent(s) ☐ **Birth** ☐ **Common Law** ☐ **Marriage** ☐ **Other**	**Last Name**	**First Name**	**Birthday** Month	Day	Year	**Relationship**	**Sex**	**Date of Marriage/Beginning of Cohabitation (required):**

Remove Dependent(s) ☐ **Separation** ☐ **Divorce** ☐ **Death** ☐ **Other**	**Last Name**	**First Name**	**Birthday** Month	Day	Year	**Relationship**	**Sex**	**Date of Separation/Divorce or Death (required):**

Extended Health and Dental Coordination or Waiver

☐ My other coverage terminated on _____/_____/_____. If I have previously waived extended health and dental coverage please reinstate.

☐ I have other comparable coverage in effect - The information below must be completed if you and/or your dependents have comparable coverage provided under another plan

_____	_____	_____	_____
Name of Insurance Company	**Group No.**	**ID. No.**	**Effective Date**

By checking the boxes below, I am choosing to decline the benefit for myself and my dependents... ☐ Extended Health Care ☐ Dental Care

OR

By checking the boxes below, I am choosing to decline the benefit for my dependents only... ☐ Extended Health Care ☐ Dental Care

Authorization

I hereby confirm the above information is complete, true and accurate

Plan Administrator Signature Date:

Employee Signature Date:

All changes must be submitted within 31 days of the effective date, delayed forms may experience eligibility and/or premium implications. Details regarding the termination of employment, salary change or a class/division transfer can be emailed to hr@bccabenefits.ca