TRIO, PO Box 14225 (Manuels),
CBS, NL, A1W 3J1

Benefit Change Form

trio
Life·Health·Pension

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 Day	Mon	Yr	Sex M/F	Children Status 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