

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Annual Salary | <input type="checkbox"/> Dependent | <input type="checkbox"/> Address / Telephone | <input type="checkbox"/> Marital Status |
| <input type="checkbox"/> Name Change | <input type="checkbox"/> Employment Type | <input type="checkbox"/> Benefit Change | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Beneficiary | <input type="checkbox"/> Termination of Member | | |

3. New Employment Type (Class)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Full Time (A) | <input type="checkbox"/> Part Time (C) | <input type="checkbox"/> Seasonal (B) | <input type="checkbox"/> Elected Member (D) |
| <input type="checkbox"/> Early Retirees (E) | <input type="checkbox"/> Over 65 Retirees | <input type="checkbox"/> Other Class _____ | |
| <input type="checkbox"/> Annual Earnings:\$ _____ Earnings per: <input type="checkbox"/> Hour \$ _____ <input type="checkbox"/> Week \$ _____ <input type="checkbox"/> Month \$ _____ | | | |

4. Dependent(s)

	Birth Date			Sex M/F	Children Status if over age 21 S = Student D = Disabled	A-Add C-Change T-Terminated
	Day	Mon	Yr			
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)	<input type="checkbox"/> Single <input type="checkbox"/> *Couple <input type="checkbox"/> Family	*Couple coverage only available to Small Town Plans
Dental	Effective Date (DD/MM/YY)	<input type="checkbox"/> Single <input type="checkbox"/> *Couple <input type="checkbox"/> Family	

7. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

<p>BENEFICIARY DESIGNATION</p> <p>Applies to Basic Life, Basic AD&D as well as any Optional Life and Optional AD&D, unless otherwise stated.</p>	<p>I name the following Beneficiary and reserve the right to change or cancel this at a later date</p> <p>_____ Date of Birth _____ <small>First Name(s) Last Name Relationship DAY MON YR</small></p> <p>If Beneficiary is under 18, please name Trustee. _____ <small>First Name(s) Last Name</small></p> <p>In the event that my Beneficiary predeceases me, the following Contingent Beneficiary shall be entitled to the benefits:</p> <p>Name: _____ Date of Birth _____ <small>DAY MON YR</small></p> <p style="text-align: center;">X Signature of Insured _____ Date _____ <small>DAY / MON / YR</small></p>
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