STANDARD LIFE

Group Life & Health

Notice of change

Administration department

Toronto
P.O. Box 4105, Postal Station A
Toronto, Ontario M5W 2P4

Montréal
P.O. Box 4002, Postal Station B
Montréal, Québec H3B 4M2

Policyholder name	Policy no.	Division no.

(1) Certificate no.	(2) Class of participant	(3) Surname	Given name (s)	Initial	(4) Code *(see over)*	(5) Effective date* of change *(YYYY/MM/DD)*	(6) Date of permanent employment *(YYYY/MM/DD)*	(7) Gender	(8) Date of birth *(YYYY/MM/DD)*	(9) Province of residence	(10) Salary Amount	Frequency	No. of hours	(11) Type of coverage required	(12) Lan-guage	(13) Details

Date *(YYYY/MM/DD)*	Signature of plan administrator	Telephone no.

* If the effective date of the change is different from the contract provisions, specify the reasons for the request in column 13, otherwise the date specified under the contract will be applied.

see over for instructions >>

How to complete the "notice of change" form

1. Use letter under "CODE" column to indicate the type of change required and complete the appropriate columns.
2. Complete this form and send the original to Standard Life.
3. Keep the second copy for your files.
4. If your policy is self-billed and you validate the beneficiary designations, keep the original forms (application, etc.) and send a copy to Standard Life.

Explanation of codes (to be indicated in column 4 on the reverse)

Code	Change	Procedure	Columns to be completed
N	New participant	Have participant complete and sign Application form GE8000. Indicate eligibility date for insurance in column 5. Indicate in column 13 the date on which the participant's status changes from part-time or temporary to permanent full-time, if applicable, and give brief explanation.	1, 2, 3, 4, 5, 6, 13 Self-Billed Policy: 1 to 13
T	Cancellation of coverage (Permanent termination)	Indicate the date of the day following the participant's termination.	1, 3, 4, 5
R	Reinstatement of insurance (following permanent termination)	Indicate the date of return to work. Verify the reinstatement of coverage clause to determine if the employee is to be considered as a new participant.	1, 3, 4, 5
S	Income • A : Annual • M : Monthly • W : Weekly • O : Hourly • D : Every two weeks	Indicate the participant's new income and the effective date of this new income. Specify the frequency using the codes on the left. In the case of hourly salaries (O), indicate the number of working hours per week.	1, 3, 4, 5, 10
CP	Class of participant	Indicate the name of the new class of the participant or the class number, if known, and the effective date.	1, 2, 3, 4, 5
C	Coverage	Indicate the new type of coverage required: • **I** Participant only (individual) • **F** Participant with dependents (family) Have participant complete and sign Request for change (I) form GE8001, sections I, II, III and specify the reason for the change.	1, 3, 4, 5, 11, 13
NC	Name	Have participant complete and sign Request for change (I) form GE8001, sections I, II, X. If a correction is needed, specify the correction to be made in column 13.	1, 3, 4, 5, 13
B	Beneficiary	Have participant complete and sign Request for change (I) form GE8001, sections I, II, VII, VIII, IX, if applicable.	1, 3, 4
EB	Exemption from benefits	Have participant complete and sign Request for change (I) form GE8001, sections I, II, V, VI. Use only if participant is already covered under spouse's group insurance plan.	1, 3, 4, 5
OB	Optional benefits	Have participant complete and sign Optional benefits form GE8002. To be completed for addition of benefits, changes and cancellations.	1, 3, 4, 13
DT	Division transfer	Specify in column 13 "Transfer from division **X** to division **Y**". If the transfer also involves a change of class, enter CP code on a second line.	1, 3, 4, 5, 13
X	Other: specify	Provide all necessary information and documents to process the change.	1, 3, 4, 5, 13

Temporary absence

Code	Change	Procedure		Columns to be completed
M1*	Temporary lay-off	With cancellation of coverage	The option elected must apply to all your employees under the policy.	1, 3, 4, 5
M2*	Temporary lay-off	Continuation of coverage (with the exception of disability benefits)	The option elected must apply to all your employees under the policy.	1, 3, 4, 5
K*	Maternity, parental or compassionate leave	Continuation or non-continuation of benefit	Have participant complete and sign Request for change (II) form GE8003, sections I, II.	1, 3, 4, 5
W	Return to work	Reinstatement of coverage	The effective date of the change indicated in column 5 must be the date of return to work.	1, 3, 4, 5

* Before using M1, M2, or K codes, please refer to the "Termination of insurance" clause under the policy.