CHANGE REQUEST

Group insurance plan for the retired members of QPAT

This form must be returned to: QPAT
17035 Brunswick Boulevard
Kirkland, Quebec H9H 5G6

TO BE COMPLETED AND SIGNED BY THE QPAT PLAN ADMINISTRATOR (Please print in ink)

Group policy no.: ☐ 97000 ☐ 97001 Division no. _____ Certificate no _____

Retired member's name (as indicated in our records) _____

Plan administrator's signature _____ Date Y M D

Plan administrator's email _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE RETIRED MEMBER (Please print in ink)

1. BASIC INFORMATION

First name _____ Last name _____

2. CHANGE OF NAME, ADDRESS OR BANKING INFORMATION

New first name _____ New last name _____ Gender: ☐ M ☐ F

New address _____
No. Street Apt. City Province Postal code

Effective date of address change (if applicable) Y M D Language: ☐ English ☐ French

Email* _____

Direct deposit of your health claim reimbursements and notification of claim processing

Banking information for direct deposit: _____ _____ _____
Transit no. (5 digits) Institution no. (3 digits) Account no.

☐ I want to be notified by email* of the status of my claims ☐ I do not want to be notified

*Your email address will not be sold to or shared with any third party, unless otherwise authorized.

3. CHANGE OF COVERAGE

Reason:

☐ Marriage/Civil Union – Date Y M D ☐ Common-law spouse[1] – Cohabitation began on Y M D

☐ Divorce/Separation – Date Y M D ☐ Birth/Adoption – Date Y M D

☐ New coverage under spouse's plan – Began on Y M D

☐ Termination of coverage under spouse's plan – Terminated on Y M D

☐ Other, specify _____ – Date Y M D

[1]If your spouse is a common-law spouse, the cohabitation period must be minimum one year.

HEALTH INSURANCE

I want to change my coverage to:

☐ Individual (participant only) ☐ Single parent (participant and children) ☐ Family (participant, spouse and children)

☐ Exemption – I request to be exempted from the health insurance benefit because I am covered as a dependent under my spouse's plan:

Spouse's name _____ Policy no. _____

Insurer _____

BASIC LIFE INSURANCE (optional)

Retired member: ☐ Terminate coverage
Spouse: ☐ Terminate coverage

ADDITIONAL LIFE INSURANCE (optional)

Retired member: ☐ Terminate coverage
Spouse: ☐ Terminate coverage

4. DEPENDENT INFORMATION

	First name	Last name	Gender	Date of birth (YYYY-MM-DD)		
☐ Add spouse[1] ☐ Remove spouse			☐ M ☐ F	Y M D	Date of marriage Y M D Or cohabitation since Y M D	
☐ Add child ☐ Remove child			☐ M ☐ F	Y M D	If age 18 or over specify	☐ Full-time student ☐ Disabled
☐ Add child ☐ Remove child			☐ M ☐ F	Y M D	If age 18 or over specify	☐ Full-time student ☐ Disabled

[1]If your spouse is a common-law spouse, the cohabitation period must be minimum one year.

5. APPOINTMENT OR CHANGE OF BENEFICIARY *(If you do not appoint a beneficiary, the benefit will be payable to the estate.)*

If you name multiple beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

First name	Last name	Relationship	Date of birth (YYYY-MM-DD)	%
			Y M D	
			Y M D	
			Y M D	

IMPORTANT: For Quebec residents only – to be completed if you appoint your spouse (marriage or civil union) as a beneficiary.

In Quebec, the designation of a spouse, excluding a common-law spouse, as a beneficiary is irrevocable* unless you check the following box: ☐ Revocable beneficiary

* To change the appointment of an irrevocable beneficiary, his/her written consent will be required.

As irrevocable beneficiary, I agree to the change of beneficiary designation.

Irrevocable beneficiary's first name _____ Last name _____

Irrevocable beneficiary's signature _____ Date Y M D

METHODS OF PAYMENT

☐ Monthly. I authorize Retraite Québec to deduct the insurance premiums from my RREGOP pension.

My social insurance number is

☐ Annually. I authorize QPAT to invoice me.

Retired member's signature _____ Date Y M D

RETIRED MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, **I CONFIRM** that I am authorized to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information provided to my Employer/Policyholder and Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and determining coverage for myself and my dependents in my Employer's/Policyholder's group insurance plan.

If my Social Insurance Number is used as my certificate number, **I AUTHORIZE** its use for the administration of my group insurance plan.

If I enrol in direct deposit, **I AUTHORIZE** iA Financial Group to deposit in my bank account, using the banking information I have provided in section 3, any amounts payable in regards to a claim that I submit under my group insurance plan. **I AGREE** that this authorization will apply until such time as I submit a written request to the contrary to iA Financial Group. **I UNDERSTAND** that iA Financial Group will have no further obligation with regard to the claims paid. **I ALSO UNDERSTAND** that iA Financial Group can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future.

Furthermore, if I enrol in direct deposit, **I UNDERSTAND** and **AGREE** that if I provide iA Financial Group with incorrect banking information or if I fail to notify iA Financial Group of any change in my banking information and, as a result of this error or omission, the amount of a paid claim is deposited into the wrong bank account, iA Financial Group cannot be held responsible or liable for this error or omission or be obligated to reimburse me if iA Financial Group is unable to recover the amount that was paid into the wrong account.

I AGREE that a photocopy of this confirmation/authorization shall be as valid as the original.

Retired member's signature _____ Date Y M D

DISCLOSURE

At Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for the purposes you have authorized. Your personal file will be kept at iA Financial Group's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, send a written request to: iA Financial Group, Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec, G1K 7M3.

Access to your personal information will be limited to employees, agents, reinsurers and service providers of iA Financial Group in the performance of their duties, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, iA Financial Group may release to your Employer/Policyholder statistical financial information without personal identifiers.

iA Financial Group is a business name and trademark of
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