



BASIC GROUP CRITICAL ILLNESS INSURANCE CHANGE REQUEST FORM

For Office Use Only

1 Policy Information

Group Policyholder Name

Group Policy Number

Division Name

Division Number

2 Employee Information

Last Name

Given Name

Initials

Member/Employee ID

3 Change Request (Please check all that apply)

Name Change:

Last Name

Given Name

Initials

Termination:

Provide last day of work

Reinstatement:

Provide date rehired

Division Transfer:

Provide transfer date

New Division Name

New Division Number

Leave of Absence:

Provide type of leave

Provide date of leave

Provide expected return date

Return to work following Leave of Absence:

Provide date of return

Employee Classification Change:

Other:

4 Completed By

Benefit Administrator Name

Date

5 Please mail or fax the Change Request Form to:

Industrial Alliance Pacific Insurance and Financial Services Inc.
Attention: Special Markets Group
Mail: 2165 Broadway West
PO Box 5900
Vancouver BC V6B 5H6
Toll Free Fax: 1-888-553-5433