CHANGE OF MEMBER INFORMATION

- Please be sure to indicate your Account/Division number, name and Member ID number or Social Insurance Number.
- Please print clearly in ink and initial any corrections.
- When changing information from the current record, **enter only the new information in the appropriate section** of the form.
- If it is a name change, enter both the current and new name in that section of the form, please forward appropriate documentation.
- You must make an application without delay to have your dependent insured otherwise evidence of insurability may be required.
- When adding:
  - A new child – show **date of birth** in effective date section. Include (or send when received) - copy of Birth Certificate .
  - A spouse – show **date of marriage** in effective date section. Include (or send when received) - copy of Marriage Certificate.
  - A Common Law Spouse – complete and sign Section #4 indicating the first **date of living together**
- Please remember that it is important that we have your current address on file.
- Notification of changes must be received by the ARA within **31 days** of the date of change & are subject to the limitations setout in the Plan Policy.
- Return this form directly to: **Automotive Retailers Association, #1–8980 Fraserwood Court, Burnaby, BC V5J 5H7**

1. EMPLOYEE DETAILS:

Acct/Div Number		**Class**		**Company Name**			
Last Name:		**First Name:**		**Member ID** (or SIN #)			
Type Of Change(s)	☐ Class Change ☐ Name Change ☐ Marital Status ☐ Address Change ☐ Coverage Status Change ☐ New Dependent ☐ Beneficiary Change			**Effective Date of Change(s):** Month / Day / Year			
Marital Status:	☐ Single ☐ Widowed ☐ Separated* ☐ Divorced* ☐ Common-Law* ☐ Married* ⇨ ***Complete applicable information below***						
Mailing Address:							
City:		**Province:**		**Postal Code:**		**Phone:**	( )

2. COVERAGE STATUS

PLEASE SELECT THE NEW STATUS TO BE APPLIED TO YOUR COVERAGE:

Extended Health Benefits: ☐ Single ☐ Couple ☐ Family ☐ Waived

Dental: ☐ Single ☐ Couple* ☐ Family* ☐ Waived*

Do you or your spouse have coverage through another source?
Extended Health Benefits ☐ No ☐ Yes ⇨☐ Single☐ Family
Dental ☐ No ☐ Yes ⇨☐ Single☐ Family
If Yes: please complete this information ⇨

Other Source Plan Details: ☐ Spouse ☐ Parent ⇨Name:
Employer:_____ Group Number:_____
ID Number: Insurance Company:

3. DEPENDENT INFORMATION

Include	Remove	Relationship	Last Name	First Name	Sex	Date of Birth Month	Day	Year	Student* *	Disabled **
		Spouse			**M F**				**Y N**	**Y N**
		Child			**M F**				**Y N**	**Y N**
		Child			**M F**				**Y N**	**Y N**
		Child			**M F**				**Y N**	**Y N**

** There are additional forms to complete for dependent children age 21 or older to verify full-time student status or disabled status

4. COMMON LAW SPOUSE INFORMATION:

For Common Law Status: I, the undersigned, hereby certify that I have been living common-law with the above named spouse and representing him/her as my spouse or my common-law spouse since: (*date*) _____. I certify that I do not have or wish to provide coverage to my otherwise legal spouse, if any.

Employee Signature:

5. BENEFICIARY DESIGNATION:

I hereby designate as revocable beneficiary in the event of my death: *{Please use full legal name(s)}*

Name:_____ **Relationship:**_____

Name: **Relationship:**

IMPORTANT – You must sign and date the form

I hereby authorize the use of my social insurance number for internal identification purposes only. I am authorized to disclose information about my spouse and dependents in order to enroll them in my Benefits Plan. By enrolling in the Benefit Plans, I authorize the following 1) Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims 2) My employer and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required 3) Sun Life Assurance Company of Canada, my employer and ARA to exchange information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the Benefit Plans. I declare that the information provided in this form is true and accurate. A photocopy or electronic version of this authorization is as valid as the original and shall remain in effect until withdrawn by me in writing.

Signature:_____ **Date Signed:**_____

(OFFICE USE ONLY)

ASSN	PART #	EFFECTIVE DATE MONTH YEAR	DAY		CLASS	EXTENDED HEALTH STATUS	DENTAL STATUS	MEMBER ID CARD	DRUG CARD SENT	BOOKLET SENT