Public Service Group Insurance Fund
Application for Changes to Dependents Insurance

Personal Information – To be answered in full by employee, please print

Name of Employee _____
(Last Name) (Given Names in Full)

Employee Number _____SIN _____ Date of Birth ____/____/____
YY MM DD

Application for Changes to Dependents' Insurance

I hereby apply for Dependents Life Insurance which insures my eligible dependents as selected below. I understand that the Dependents Insurance Plan does not insure spouses age 70 or over*. I also authorize my employer to make the necessary deductions from my earnings. I understand that the insurance payable on the death of an eligible dependent will be payable to me if living, otherwise to my Estate.

I hereby apply for Dependents Life Insurance as indicated below (a selection MUST be made by placing an "X" in the appropriate space):

☐ **1 Unit** (Spouse $17,500* Each Eligible Child $3,500*)	☐ **2 Units** (Spouse $35,000* Each Eligible Child $7,000*)	☐ **3 Units** (Spouse $52,500* Each Eligible Child $10,500*)	☐ **4 Units - Maximum** (Spouse $70,000* Each Eligible Child $14,000*)

* see the Dependents Insurance section of the Group Insurance Information booklet for eligibility requirements

I am aware that if I elected "No Dependents Coverage" at the time of eligibility or if I chose less than the maximum of 4 Units, I will have to provide my employer with medical evidence of insurability that is satisfactory to The Insurance Company if at a later date I wish to insure these eligible dependents or increase the Units. Any costs incurred in providing evidence of insurability will be at my expense. I am also aware that if I presently do not have eligible dependents or I previously opted out of the Dependents Insurance Plan, I may insure newly acquired eligible dependents without providing evidence of insurability if I notify my employer within 90 days of acquiring the eligible dependent. Any changes to the above must be initialed by the employee.

Employees wishing to insure a common-law spouse should contact their employer for the required forms.

Dependents (including spouse) – all eligible dependents must be listed	Relationship to Life Insured	Birthdate
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____ YY MM DD

_____ _____
Signature of Insured Member Date

_____ _____
Witness to the Above Signature Date

Application to Cancel Dependents' Insurance

I hereby elect to cancel Dependents' Insurance on all my eligible dependents.

_____ _____
Signature of Insured Member Date

_____ _____
Witness to the Above Signature Date