

**Public Service Group Insurance Fund**  
**Application For Changes To The Dependents Insurance Plan - Policy 330785**  
**(For completion by employees currently enrolled in the Dependents Insurance Plan)**

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

Name of Employee \_\_\_\_\_  
(Last Name) (Given Names in Full)

Employee Number \_\_\_\_\_ Certificate No./SIN \_\_\_\_\_ Date of Birth \_\_\_\_\_  
YYYY MM DD

**Complete Only the Applicable Sections**

**1. Addition of New Dependents**

I wish to add the following eligible dependents to my existing dependents insurance coverage:

Spouse\*: Last Name: \_\_\_\_\_ Given Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date of Marriage: \_\_\_\_\_ Date Common-Law Cohabitation Commenced \_\_\_\_\_

Children\*\*: Last Name: \_\_\_\_\_ Given Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Name: \_\_\_\_\_ Given Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Eligibility:**

\* assumes spouse (legally married) or common-law spouse (a common-law spouse is considered an eligible dependent only if the employee and common-law spouse have cohabited for a period of one year and the request for the addition of the common-law spouse into the dependent plan has been signed and dated within 90 days after fulfilling the one year cohabitation requirement) is under age 70. Employee is entitled to coverage on one spouse only.

\*\* All children, other than natural children of the employee, must be in the care and custody of the employee and assumes each eligible child is unmarried and under age 22. However, coverage on a disabled dependent child over age 22 may be continued if application is approved by The Insurance Company. Coverage on a disabled child ceases at age 70.

All dependents must reside in Canada or the USA and not in military service.

**All questions regarding eligibility of your dependents should be directed to The Civil Service Superannuation Board.**

**2. Deletion of Dependents**

I wish to continue dependents insurance coverage but wish to delete only the following dependent(s):

Last Name: \_\_\_\_\_ Given Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last Name: \_\_\_\_\_ Given Name \_\_\_\_\_ Relationship \_\_\_\_\_

Dependents coverage on a common-law spouse ends automatically when a separation of the relationship occurs. No claim will be payable as of the date of separation. Employees must provide the employer with written notification of the separation as the employee will not be eligible for a refund of premiums (if applicable) retroactively. Coverage on a legally married spouse ends automatically only on the date of divorce.

**3. Request for Changes to the Number of Units of Dependents Insurance Coverage**

I currently have \_\_\_\_\_ Units of Dependents coverage and wish to increase/decrease to \_\_\_\_\_ Units of Dependents coverage. An increase in units must be approved by the Insurance Company. Contact your employer for the required application forms.

**4. Cancellation/Rejection of Dependents Insurance Coverage**

\_\_\_\_\_ I hereby elect to cancel/reject the dependent insurance coverage on all of my dependents.

\_\_\_\_\_  
Signature of Insured Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to the Above Signature

\_\_\_\_\_  
Date