canopy *health* insurance

CHANGE REQUEST FORM

PLEASE USE BLOCK LETTERS, TYPE OR PRINT WHEN COMPLETING THIS FORM

GENERAL INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Member/Employee Name

Member Number

EMPLOYER/COMPANY NAME

Member Tax Registration Number

CHANGE OF DEPENDENT STATUS - LIST DETAILS BELOW (TO BE COMPLETED BY EMPLOYEE)

TELL US WHAT YOU WOULD LIKE TO BE CHANGED

☐ Cancel all Dependent Coverage ☐ Cancel Dependent Coverage (as listed below) ☐ Add Dependent(s) (as listed below)

D D M M M Y Y

Effective Date of change

LAST NAME	FIRST NAME	MI	SEX	RELATIONSHIP	DATE OF BIRTH	TRN
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	

REASON FOR ADDITION OF DEPENDENT COVERAGE:

☐ MARRIAGE
☐ BIRTH OF CHILD
☐ OTHER (Specify) _____

(sumbit supporting documents)

REASON FOR DELETION OF DEPENDENT COVERAGE:

☐ DIVORCE/DEATH OF DEPENDENT
☐ COMMENCEMENT OF DEPENDENT EMPLOYMENT
☐ OTHER (Specify) _____

I agree to any change in contribution necessitated by the requested change in coverage.

CHANGE/CORRECTION OF NAME (TO BE COMPLETED BY EMPLOYEE)

PLEASE CHANGE THE NAME OF THE : ☐ **EMPLOYEE** ☐ **DEPENDENT**

FROM (NAME CURRENTLY ON FILE): LAST NAME / FIRST NAME / MI

TO (INTENDED NAME): (sumbit supporting documents) LAST NAME / FIRST NAME / MI

REASON FOR NAME CHANGE: ☐ **MARRIAGE** ☐ **OTHER (SPECIFY)**

CORRECTION OF DATE OF BIRTH/GENDER

PLEASE CHANGE THE DETAILS OF THE: ☐ **EMPLOYEE** ☐ **DEPENDENT** **NAME**

FROM (date currently on file): D D M M M Y Y DATE OF BIRTH

FROM (gender currently on file): M F GENDER

TO (intended date): (sumbit supporting documents) D D M M M Y Y DATE OF BIRTH

TO: M F GENDER

APPOINTMENT/CHANGE OF BENEFICIARY

I _____ do hereby revoke any previous designation or appointment of beneficiary(ies) with respect to said Group Life Policy and now designate and appoint as indicated below:

BENEFICIARY NAME	RELATIONSHIP	LIFE%	DATE OF BIRTH	GENDER	TRUSTEE NAME
			D D M M M Y Y	M F	
			D D M M M Y Y	M F	
			D D M M M Y Y	M F	
			D D M M M Y Y	M F	

SIGNATURE OF EMPLOYEE | DATE | SIGNATURE OF WITNESS

| CHANGE REQUEST FORM

(If employee is applying for coverage outside of eligibility period, please complete the Health History Questionnaire)

HEALTH HISTORY QUESTIONNAIRE

THIS HEALTH HISTORY QUESTIONNAIRE IS BEING COMPLETED FOR: ☐ Employee Only ☐ Employee & Dependents ☐ Dependent(s) only

NAME	HEIGHT	WEIGHT	GENDER	RELATIONSHIP	DATE OF BIRTH	TRN
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	
			M F		D D M M M Y Y	

PERSONAL HEALTH HISTORY (TO BE COMPLETED BY EMPLOYEE)

(NOTE: IF QUESTIONNAIRE IS BEING COMPLETED FOR NEW DEPENDENTS, GIVE DETAILS ONLY FOR DEPENDENTS)

FOR THE EMPLOYEE	YES	NO
1. Are you employed by the employer named on this form for more than 30 hours per week?	☐	☐
FOR THE EMPLOYEE AND/OR DEPENDENTS KINDLY RESPOND 'YES' OR 'NO' TO THE FOLLOWING QUESTIONS.		
2. During the last 5 years, have you or any of your dependents consulted, been examined or treated by a Doctor, or been advised to have any diagnostic tests (e.g. blood tests, X-Rays, CAT Scan, MRI) etc.?	☐	☐
3. During the last 5 years, have you or any of your dependents undergone a surgical operation, or been treated in any hospital or other institution?	☐	☐
4. Have you or any of your dependents been treated for, or been told that you have Heart Trouble, Blood Disease, High Blood Pressure, Kidney Disorder, Diabetes, Tuberculosis, Cancer, Tumor, Ulcer, Asthma, Epilepsy, Alcoholism, Mental Disorder, or any other disease not listed anywhere on this application?	☐	☐
5. Have you or any of your dependents been diagnosed with, or treated for HIV, AIDS, or ARC (AIDS related complications) (If 'Yes', underline disease.)	☐	☐
6. Are you or any of your dependents now receiving, contemplating, or been advised to seek any medical attention or surgical treatment, or taking any medication?	☐	☐
7. Do you or any of your dependents have any disorder of the female organs or breast?	☐	☐
8. Are you or any of your dependents now pregnant?	☐	☐
9. Do you or any of your dependents have any physical impairments?	☐	☐
10. Do you or any of your dependents have any prior or existing history of alcoholism or drug abuse?	☐	☐
11. Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way?	☐	☐

IF THE RESPONSE TO ANY OF QUESTIONS 2-11 IS 'YES', GIVE COMPLETE DETAILS BELOW (CONTINUE ON ANOTHER SHEET, IF NECESSARY)

QUESTION NO.	FULL NAME OF PERSON TREATED	NATURE OF AILMENT	DEGREE OF RECOVERY: (FULL, PARTIAL OR CONTINUING)	NAME AND ADDRESS OF ATTENDING MEDICAL PROFESSIONAL	DATE OF VISIT

I declare that all the statements on this form are full, true and complete, and I understand that they form the basis upon which any insurance will be made effective. I authorize the physician, hospital or other medically related facility to disclose to Canopy Insurance Limited information about my health, habits or medical history, as well as that of any dependents listed above. It is further understood that Canopy Insurance Limited reserves the right to request an examination by a Physician of their choice to aid its decision.

SIGNATURE OF EMPLOYEE

DATE

COMPANY STAMP

NAME OF AUTHORIZED OFFICER OF EMPLOYER

POSITION OF AUTHORIZED OFFICER OF EMPLOYER

SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

DATE