

Important: Fill out in block letters and answer each section as accurately as possible.

Section A—Collection, Use and Disclosure of Personal Information

By completing this form and providing personal information about yourself and your dependents, if any, you authorize UV Assurance to process your request regarding the change(s) in question.

The personal information is used to:

- ▶ Identify the individual
- ▶ Establish and update information and the needs of the individual, as appropriate
- ▶ Comply with legal and regulatory requirements, including tax rules and the prevention, detection and enforcement of offences, cyber threats and fraud

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing the application, as well as to any other person authorized by law.

Section B—Member Information

1. Employer name _____
2. Employee first name _____ Last name _____
3. Group # _____ Billing unit _____ Class _____ Certificate # _____

☐ Section C—Change of Address (New Address)

Address (number, street, apt.) _____
City _____ Province _____ Postal code _____

☐ Section D—Change of Coverage

1. Desired protection

- | | | | | | |
|-------------------------------------|---------------------------------|--|---------------------------------|-------------------------------------|------------------------------------|
| a) Dependent | ☐ Couple | ☐ Single parent | ☐ Family | | |
| b) Health insurance | ☐ Couple | ☐ Single parent | ☐ Family | ☐ Individual | ☐ Exemption |
| c) Dental insurance (if applicable) | ☐ Couple | ☐ Single parent | ☐ Family | ☐ Individual | ☐ Exemption |

2. Reason ☐ Birth ☐ Marriage ☐ Adoption ☐ Common law partner ☐ Start of cohabitation _____
☐ Job loss ☐ Separation ☐ Divorce ☐ Dental (optional) ☐ Effective date of change _____

3. Dependents

Change	First name, last name	Sex	Date of birth	* Preuve requise	
Spouse ☐ Add ☐ Delete ☐ Edit		☐ M ☐ F	_____	Full-time student (21+)	Disabled*
Child 1 ☐ Add ☐ Delete ☐ Edit		☐ M ☐ F	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child 2 ☐ Add ☐ Delete ☐ Edit		☐ M ☐ F	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child 3 ☐ Add ☐ Delete ☐ Edit		☐ M ☐ F	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child 4 ☐ Add ☐ Delete ☐ Edit		☐ M ☐ F	_____	☐ Yes ☐ No	☐ Yes ☐ No

4. Exemption request

Exemption - member and dependents → ☐ Health and drug coverage ☐ Dental coverage
 Exemption - dependents only → ☐ Health and drug coverage ☐ Dental coverage

5. End of exemption

Date at which it became impossible for me to continue to be covered by a comparable plan _____
 Reason for terminating the insurance _____

Section E—Change of Beneficiary

Note: In Quebec, if no beneficiary is named, the designation of a spouse or civil partner is irrevocable and the designation of any other beneficiary is revocable.

First name	Last name	Relationship	%	Irrevocable	Revocable
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Signature of current beneficiary (if current designation is irrevocable)

I agree to be revoked as the current irrevocable beneficiary of the above-mentioned contract and I waive all my rights and privileges under said contract.

X _____ Date

	Y		M		D
--	---	--	---	--	---

Change of current beneficiary Name of signatory (please print)

Note: 1. The revoked beneficiary cannot consent to the change if they have not yet reached the age of 18.
2. If the current irrevocable beneficiary is deceased, please provide us with proof of death (e.g., death certificate).

Signature of the employee

I hereby revoke the current designation and replace it with that of the new beneficiary as indicated above.

X _____ Date ____ / ____ / ____
Signature of the employee Name of signatory in block letters

Section F—Consent and Signature

By signing, you understand that in the event any of your personal information is inaccurate, incomplete, or ambiguous, you may request a correction by contacting UV Insurance. You also have the right to request information about how your personal information is used.

In addition, you may withdraw your consent to the disclosure or use of your personal information at any time by making a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

For more details, please visit our website and see our **Privacy Policy**.

Signature of the employee

- ▶ I certify that I have read all the information contained in this document and that the information provided is complete and true;
- ▶ I consent to the collection, use, and disclosure of the personal information contained herein. This consent also applies to the collection, use, and disclosure of personal information of beneficiaries and/or my dependents, as applicable;
- ▶ I understand that a photocopy of this consent form has the same value as the original.

X _____ Date

Y	M	D
---	---	---

Signature of the employee Name of signatory (please print)

Signature of Plan Administrator

I certify, as an authorized person for this group, that I have read and agreed to the information in this form.

X _____ Date

Y	M	D
---	---	---

Signature of plan administrator Name of signatory (please print)

