MEMBER BENEFIT CHANGE FORM

OASSIS
BENEFIT PLANS FOR NOT-FOR-PROFITS

Employer Information	Employer / Agency:	Location Number (_ _ _ ASO _ _ _ _) :	
Plan Member Information	Member Last Name	Member First Name	Date of Birth Certificate or GSC #: XLR -00

Change Policy

A change request to add health and dental coverage due to a **Qualifying Life Event** must be submitted to OASSIS within **31 days** from the life event. If written notice is received after 31 days from a life event, benefits coverage will be subject to proof of good health with the carriers and any applicable plan restrictions/limitations.

Qualifying Life Events include: a) marriage or any other formal union recognized by law, or common-law; **b)** birth or adoption of a child; **c)** divorce or legal separation; **d)** loss of alternate benefit coverage; **e)** death of a dependent; **f)** the date a dependent child is no longer eligible for benefits, g) new provincial health insurance

A change request to add health and dental coverage without a life event will be subject to proof of good health with the carriers and any applicable plan restriction/limitations.

A change request to remove health and dental coverage does not require a life event. However, proof of alternate coverage is required to remove health and dental benefits for the employee. If, at a later date, a request is made to add coverage back without a life event, benefit coverage will be subject to proof of good health with the carriers.

Note: To be eligible for the health and dental benefit, you and any dependents are required to have provincial health insurance plan. The group benefit plan is intended to supplement your provincial health insurance plan.

Changes to Extended Health and /or Dental

Please check the appropriate box and provide the effective date of the change.

Extended Health Coverage
☐ **Add** ☐ **Remove**
Effective Date (YYYY-MM-DD): _____

Dental Coverage
☐ **Add** ☐ **Remove**
Effective Date (YYYY-MM-DD): _____

Coordination of Benefits
☐ **Add** ☐ **Remove**

☐ **Health** Single Family
☐ **Dental** ☐ Single ☐ Family

Effective Date:
Insurance Company:
Name of Insured:
Policy / Member #:

Qualifying Life Event for this Change?
Please Select
If yes, indicate Qualifying Event:
N/A - No Qualifying Life Event
Qualifying Life Event Date:
Alternate Insurer Name:
Alternate Insurer Policy #:

Dependent Information

	Last Name (If different than employee)	**First Name**	**Date of Birth (YYYY-MM-DD)**	**Gender**	**Full-time Student? (21-25)**	**Disabled Dependent (age 21 & over)**
Spouse* ☐ Add ☐ Remove ☐ Change				☐ Male ☐ Female ☐ Other	N/A	N/A
Child ☐ Add ☐ Remove ☐ Change				☐ Male ☐ Female ☐ Other	☐ Yes ☐ No	☐ Disabled
Child ☐ Add ☐ Remove ☐ Change				☐ Male ☐ Female ☐ Other	☐ Yes ☐ No	☐ Disabled
Child ☐ Add ☐ Remove ☐ Change				☐ Male ☐ Female ☐ Other	☐ Yes ☐ No	☐ Disabled

2024-01-29

MEMBER BENEFIT CHANGE FORM

OASSIS
BENEFIT PLANS FOR NOT-FOR-PROFITS

Employee Name Change	**New Name** Last Name: First Name:	**Effective Date (YYYY-MM-DD):**

Optional benefit coverages may differ depending on your OASSIS group plan. Some coverage may not be available to your agency. Contact your OASSIS Benefits Administrator prior to requesting coverage.

Request to Apply for Optional Benefits

Optional Employee Life Insurance	**Critical Illness Insurance**	**Dependent Life Insurance**
☐ **Add** ☐ **Remove** (Available to full time employees only, subject to medical approval by insurer, premiums based on age and smoking habits) ☐ 1x annual salary ☐ 2x annual salary ☐ Other:_____	☐ **Add** ☐ **Remove** (Available to part time and full time employees, subject to medical approval by insurer, premiums based on age and smoking habits) $_____ (available in units of $10,000 up to a maximum of $250,000)	(dependent information required) ☐ **Add** ☐ **Remove**

Authorization

Employer Authorization Required

I declare that all the information above is accurate and true. I understand that any inaccurate information may invalidate benefit coverage.

Employee Signature: _____ Date:

Employer / Authorized Contact:

Last Name: First Name: Date:

Please submit this form using one of the following methods: fax / mail / email your OASSIS Benefits Administrator

---

Note - the following changes require additional supporting forms.
The forms are located in your plan administration documents on the OASSIS website at **http://www.oassisplan.com/login** or, contact your OASSIS Benefits Administrator for required forms.

Type of Change	Name of Forms	How to Submit
Change Beneficiary Information	Beneficiary Designation Form (a copy with the handwritten member's signature is required)	email / fax / mail
Proof of Common-Law Spouse Status	Declaration of Common Law Spouse Form	email / fax / mail
Proof of Overage Disabled Dependent	Disabled Dependent Form	email / fax / mail
Proof of Full-Time School Status for Dependents Over 21 years old	Dependents Over 21 Form	email / fax / mail

OASSIS 5407 Eglinton Ave. West, Suite 208 Toronto, Ontario M9C 5K6
Phone: 416-781-2258 Toll Free: 1-888-233-5580 Fax: 647-689-3061