CHANGE OF MEMBER INFORMATION

- Please be sure to indicate your Account/Division number, Name, and Member ID.
- Completed forms should be printed and must be signed in ink. (Note that digital signatures are not valid for this form.)
- When making changes to information from the current record, only **enter the new information in the appropriate section** of the form.
- In the case of a name change, enter both the current and new name in that section of the form, and please provide appropriate documentation.
- When adding a new dependent, it is essential to promptly submit an application to have your dependent insured; otherwise, evidence of insurability may be required.
  - For a new child, please include the **date of birth** in the effective date section and provide copy of the Birth Certificate (or send it when received).
  - For a spouse, include the **date of marriage** in the effective date section and provide a copy of the Marriage Certificate (or send it when received).
  - For a Common Law Spouse, complete and sign Section #4, indicating the first **date of cohabitation**.
- Changes must be received by the ARA within **31 days** of the date of change and are subject to the limitations specified in the Plan Policy.
- Return the completed and signed form to: **Automotive Retailers Association, #1–8980 Fraserwood Court, Burnaby, BC, V5J 5H7**.

1. EMPLOYEE DETAILS:

Account/Division #		**Class:**		**Company Name:**			
Last Name:		**First Name:**		**Member ID:**			
Type Of Change(s):	☐ Marital Status ☐ New Dependent ☐ Name Change ☐ Coverage Status Change ☐ Beneficiary Update ☐ Class Update ☐ New Address ☐ Other:			**Effective Date of Change(s):**	Month	Day	Year
Marital Status:	☐ Single ☐ Widowed ☐ Separated* ☐ Divorced* ☐ Common-Law* ☐ Married* ➔ ***Complete applicable information below***						
Mailing Address:							
City:		**Province:**		**Postal Code:**		**Phone:**	

2. COVERAGE STATUS:

PLEASE SELECT THE NEW STATUS TO BE APPLIED TO YOUR COVERAGE:

Extended Health Benefits: ☐ Single ☐ Family* ☐ Waived*

Dental: ☐ Single ☐ Couple* ☐ Family* ☐ Waived*

Do you or your spouse have coverage through another source?

Extended Health Benefits ☐ No ☐ Yes ➔ ☐ Single ☐ Family

Dental ☐ No ☐ Yes ➔ ☐ Single ☐ Family

If Yes: please complete this information ➔

Other Source Plan Details: ☐ Spouse ☐ Parent ➔Name:____________

Employer:____________________ Group Number:____________

ID Number:____________Insurance Company:________________

3. DEPENDENT INFORMATION:

Include	Remove	Relationship	Last Name	First Name	Gender	Date of Birth Month	Day	Year	Student**	Disabled**
		Spouse			☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO
		Child			☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO
		Child			☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO
		Child			☐ M ☐ F				☐ YES ☐ NO	☐ YES ☐ NO

** There are additional forms to complete for dependent children age 21 or older to verify full-time student status or disabled status

4. COMMON LAW SPOUSE DETAILS:

For Common Law Status: I, the undersigned, hereby certify that I have been living common-law with the above-named spouse and representing him/her as my spouse or my common-law spouse since: (*date*) ____________________. I certify that I do not have or wish to provide coverage to my otherwise legal spouse, if any.

Employee Signature: ______________________________

5. BENEFICIARY DESIGNATION:

I hereby designate as revocable beneficiary in the event of my death: *{Please use full legal name(s)}*

Name:______________________________**Relationship:**________________

Name:______________________________**Relationship:**________________

IMPORTANT – You must sign and date the form

I hereby authorize the use of my social insurance number for internal identification purposes only. I am authorized to disclose information about my spouse and dependents in order to enroll them in my Benefits Plan. By enrolling in the Benefit Plans, I authorize the following 1) Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims 2) My employer and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required 3) Sun Life Assurance Company of Canada, my employer and ARA to exchange information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the Benefit Plans. I declare that the information provided in this form is true and accurate.

Signature:______________________________**Date Signed:**________________

(ARA USE ONLY)

ASSN	PART#	EFFECTIVE DATE MONTH	DAY	YEAR	CLASS	EXTENDED HEALTH STATUS	DENTAL STATUS	MEMBER ID CARD	DRUG CARD SENT	BOOKLET SENT

ADM 02 (07-2023)