



NOTICE OF CHANGE

CoreLink Group Insurance Plan

Employer's Name: _____ Effective Date of Change: ____/____/____
mm dd yr

Employee's Name: _____ Group Insurance Certificate # _____

<input type="checkbox"/> Salary/Occupation	<input type="checkbox"/> Dependent Status
<input type="checkbox"/> Termination	<input type="checkbox"/> Coverage
<input type="checkbox"/> Address/Telephone	<input type="checkbox"/> Other: (please specify) _____
<input type="checkbox"/> Marital Change	

1. EMPLOYEE DETAILS

New Salary	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi Monthly	Hours worked per week
	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	
	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Hourly	
Date of Termination: _____			
Address Change: Street _____ City _____ Prov _____ Postal Code _____ Tel: _____			
Marital Change: <input type="checkbox"/> Legal Marriage <input type="checkbox"/> Common Law - Date of Cohabitation _____ <input type="checkbox"/> Divorce			
Note: Common Law requires 12 months cohabitation before becoming effective.			

2. DEPENDENT INFORMATION - ADD/DELETE

	First Name & Initial (Last Name if Different)	Sex M/F	Date of Birth			Student Yes/No	A - Add D - Delete
			Mo.	Day	Yr.		
Spouse							
Child							
Child							
Child							

If your spouse is covered for Extended Health Care and/or Dental benefits by his/her employer's plan, please indicate coverage:

<u>EXTENDED HEALTH CARE</u>	<u>DENTAL</u>
<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None
Name of Carrier: _____	Name of Carrier: _____

3. COVERAGE

<input type="checkbox"/> I am ADDING	<input type="checkbox"/> Single / <input type="checkbox"/> Family	<input type="checkbox"/> Extended Health Care and/or <input type="checkbox"/> Dental Care	Reason
<input type="checkbox"/> I am DELETING	<input type="checkbox"/> Single / <input type="checkbox"/> Family	<input type="checkbox"/> Extended Health Care and/or <input type="checkbox"/> Dental Care	Reason
<input type="checkbox"/> I am CHANGING	<input type="checkbox"/> Single to Family	<input type="checkbox"/> Family to Single	Reason

I am authorized to disclose information about my spouse and dependents in order to enroll them in the Plan. All information in this form is true and complete. I agree to the Authorization and Consent on the reverse side of this form.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Please forward to: Rice Financial Group Inc., ATTN: Employee Benefits, 491 Portage Ave., Winnipeg, MB R3B 2E4

Fax: 204.786.3889

Please keep a photocopy for your records.

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held by Rice Financial Group Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and my employer, and to manage the organization's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

For additional information regarding Rice Financial Group Inc.'s Group Benefits privacy policy I can contact Rice Financial at 204-786-0324 or privacy@ricefinancial.com should I have questions as to the collection, use or disclosure of my personal information.