To complete and e-sign this form online, please open it in Adobe

The Construction Industry's Benefit Plan
Employee Change Form

To change your beneficiary, complete a *Beneficiary Designation* form.

To continue coverage for a child after age 21:

- If the child is a full-time student, complete a *Student Declaration* form
- If the child is disabled, contact us for the required form.

Attach list if adding more than 3 children to your plan, or removing more than 1 child from your plan.

Section 1 – Employee Information

Employer Company Name	Employee First Name	Employee Last Name
Employee Email	Employee Phone	Certificate No.

Section 2 – Requested Change

❑ Employee name change	❑ New First Name: ❑New Last Name:
❑ Spouse name change	❑ New First Name: ❑New Last Name:
❑ Address change	New address: City Province Postal Code
❑ Add spouse	First Name Last Name Date of birth (mm/dd/yyyy) Gender: O Male O Female O X O Common-law – provide date of cohabitation (mm/dd/yyyy) O Married – provide date of marriage (mm/dd/yyyy)
❑ Remove spouse	Name (first, last): Termination Date (mm/dd/yyyy):
❑ Add child 1	First Name Last Name Gender: O Male O Female O X Date of birth (mm/dd/yyyy) ❑ Date of adoption (mm/dd/yyyy) Relationship to you: (Attach copy of court order if you are the legal guardian)
❑ Add child 2	First Name Last Name Gender: O Male O Female O X Date of birth (mm/dd/yyyy) ❑ Date of adoption (mm/dd/yyyy) Relationship to you: (Attach copy of court order if you are the legal guardian)
❑ Add child 3	First Name Last Name Gender: O Male O Female O X Date of birth (mm/dd/yyyy) ❑ Date of adoption (mm/dd/yyyy) Relationship to you: (Attach copy of court order if you are the legal guardian)
❑ Remove child	Name (first, last): Termination Date (mm/dd/yyyy):
❑ Additional Information (Optional)	Provide information that may be necessary to explain the requested change.

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Section 3 – Coordination of Benefit information

Complete this section if you or your dependents are covered by another EHC or Dental plan, or your other plan has terminated

❑ **Add Other Coverage Information**

- This information is required to establish which plan is primary and which plan is secondary for your family's claims.
- Do not complete this section if your child(ren) are covered by the BC Healthy Kids program, as it is always the last payer and will not affect claims under your CIBP plan.

Benefits covered by other plan: ❑ EHC ❑ Dental		
Who is the cardholder of the other plan? ❑ My Spouse Spouse's birthday (mm/dd) ❑ My dependent child(ren) (e.g. Student plan through university) ❑ Other (specify):	❑ My dependent child(ren)'s non-custodial parent/step-parent (applicable only if you are the custodial parent) ❑ My dependent child(ren)'s custodial parent/step-parent (applicable only if you are not the custodial parent) ❑ My dependent child(ren)'s parent/step-parent who has joint physical custody with me. Parent/step-parent's birthday (mm/dd):	
Insurance Company:	Policy #:	Effective Date (mm/dd/yyyy):
Who is covered by this other plan? (Check all that apply) ❑ Myself ❑ My spouse ❑ All my dependent children ❑ Other - List your dependent children that are covered by this other plan:		

❑ **Remove Other Coverage Information**

- If the other plan has terminated, we will remove it from your profile so that your family's claims are not disrupted.

Benefits that were covered by this other plan: ❑ EHC ❑ Dental	Termination Date (mm/dd/yyyy):
Who was covered by this other plan? (Check all that apply) ❑ Myself ❑ My spouse ❑ All my dependent children ❑ Other - List your dependent children that are covered by this other plan	

Section 4 – Update Privacy Contacts

Add or remove individuals who can inquire on your behalf and to whom we can disclose personal information such as your SIN, dependents, beneficiary and claims.

❑ Add ❑ Remove	Name of Individual (first, last)	Relationship to Employee
❑ Add ❑ Remove	Name of Individual (first, last)	Relationship to Employee

Section 5 – Employee signature

I hereby declare that all the information provided in this form is true, correct and complete to the best of my knowledge. I consent to the personal information provided above being retained, used and disclosed in accordance with ICBA Benefit Service Ltd.'s privacy policy, a copy of which is available at icbabenefits.ca.

Employee Signature	Date signed (mm/dd/yyyy)

Return completed form to ICBA Benefits via email (indicate the policy number in the Subject line), or by mail.
If you email the form, do not also send the original by mail.

The Construction Industry's Benefit Plan - #800 - 13761 96th Avenue, Surrey, BC V3V 0E8

604 298-8957 TF: 844 393-2334 benefits@mycibp.ca mycibp.ca