



THE EMPIRE LIFE INSURANCE COMPANY

**Request for Service
Request for Employee and/or Dependant Additions,
Changes, Terminations, Supply Requisitions, and other Changes**

Policy Number _____ **Policyowner (Company Name)** _____
Telephone Number (____)____ - _____ Fax Number (____)____ - _____
Internet E-mail Address _____

Type of Employee Change(s) Being Requested

1. Termination - show date of last day worked.
2. Addition - new enrolment; **must attach fully completed and signed enrolment form and, if required, Non-Medical Declaration.**
3. Change in benefits - show new benefits.
4. Change in salary - show new salary in comments column.
5. Change in Dependant status - show single or family for benefits affected with reasons in comments column (i.e. date of marriage). If enrolling a Common Law Spouse, please complete the "Common Law Spouse Memorandum" Found on "Insured Employee Information Change Form" (G-0033). If spousal coverage terminated with other carrier, please indicate name of carrier and date of termination.
6. Advice of Overage Dependant attending college/university - show dependant name, date of birth, school name, start and end date of program.
7. Reinstatement (only within 6 months of termination of employment).
8. Change in Occupation - show occupation.
9. Change in Class - show old and new class and reason for change in comments column.
10. Addition of Dependant information - include full name, date of birth, sex and relationship to the insured employee.

Certificate Number	Employee Name	Type of Change	Change Effective Date	Comments

Signature of Authorized Company Official

Date

Supply Requisition

Policy Number _____ Division _____
Policyowner (Company Name) _____
(Please indicate required quantity)

Quantity

- _____ Request for Service; (this form). For Employee and/or Dependant Additions, Terminations and other changes.
- _____ Enrolment Card
- _____ Optional Life Enrolment Card
- _____ Non-Medical Declaration (employee)
- _____ Non-Medical Declaration (dependant)
- _____ Extended Health Benefits Claim Form
- _____ Dental Benefits Claim Form
- _____ Weekly Indemnity Claim Form
- _____ Group Life Insurance Death Claim Form
- _____ Salary/Earnings Updates
- _____ Maternity/Paternity Leave Temporary Refusal of Benefits

Employee Booklets

<u>Class</u>	<u>Number Required</u>
_____	_____
_____	_____
_____	_____

Pre-Addressed Envelopes;

_____ Small, _____ Large

Long Term Disability Forms

- _____ Claimant's Statement
- _____ Attending Physician's Statement of Disability
- _____ Group Policyowner's Statement

Mail all Correspondence to:

Employee Benefits Division
The Empire Life Insurance Company
259 King Street East
Kingston, ON K7L 3A8

Phone: (613) 548-1890 Fax: 1-888-841-9145

For assistance, call **1-800-267-0215** or e-mail **group.csu@empire.ca**