

LIFE CHANGE FORM FOR CTA MEMBER OUT-OF-COUNTRY COVERAGE THROUGH RSA TRAVEL INSURANCE INC.

Please PRINT clearly

1 Plan Member Details

Name (first, middle initial, last)				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union <input type="checkbox"/> Common Law			Coverage selection <input type="checkbox"/> Single <input type="checkbox"/> Family (Couple)		
Telephone		E-mail Address			

2 Type of Change

You must apply within 30 days of the effective date of the life-event change

- Marriage, separation or divorce
- A dependent spouse or child becomes eligible for coverage, no longer qualifies as an eligible dependent
- The birth or adoption of a child
- Accepting legal guardianship of a child
- The death of a spouse/partner or child

2 Spouse & Dependent Details

Please indicate one of the following codes: A=Addition, C=Change, T=Termination

Code	Effective Date (d/m/y)	Name (First,Last)	Date of Birth	Gender (M or F)	Relation	Student*	Overage Disabled Child**

NOTES: If you need more space, please complete on a separate sheet of paper and sign and date it.

* A student is a child age 18-25 who is a full-time student attending an educational institution recognized by CRA as long as the child is not married, in any other formal union, or entirely dependent on you for financial support.

3 Declaration and Authorization

I understand that my coverage will be effective on the date this form is received by the program administrator.

I declare that my answers in this enrollment form are true and complete.

I hereby agree to advise the program administrator of any life changes within 30 days.

I authorize RSA Travel Insurance Inc. and its agents and service providers to use and exchange information needed for underwriting, administration, and adjudicating claims and to use and exchange information with Zavitz Insurance for the purpose of administration under this benefits program.

A photocopy or electronic version of this authorization is as valid as the original.

Member's Signature	Date
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