Website: www.coughlin.ca/catca-accta | **Email:** catca@coughlin.ca
P.O. Box 3517 | Station C | Ottawa, ON K1Y 4H5 | **Tel:** 613-231-2266 **ext** 288 | 1-888-613-1234 **ext** 288

CANCELLATION / CHANGE FORM

Please complete this form in duplicate and print clearly, in INK.

POLICY HOLDER INFORMATION

MEMBER SURNAME	GIVEN NAME	INITIAL

CERTIFICATE NUMBER / PRI NUMBER	STREET ADDRESS

CITY	PROVINCE	POSTAL CODE	TELEPHONE
			( )

MARITAL STATUS	SPOUSE'S NAME
☐ Single ☐ Married/Common-law	

COVERAGE

I hereby request that the following optional life insurance be cancelled:

- ☐ Optional Life Insurance - Member
- ☐ Optional Life Insurance - Spouse
- ☐ Optional Critical Illness - Member
- ☐ Optional Critical Illness - Spouse
- ☐ Optional Dependant coverage - Child
- ☐ **Terminate all insurance benefits**
- ☐ Personal Accidental Coverage

REDUCTION OF COVERAGE

Changes:

☐ Please reduce my insurance benefit coverage from $ _____ to $ _____
(in increments of $10,000.00)

☐ Please reduce my spouse's insurance benefit coverage from $ _____ to $ _____
(in increments of $10,000.00)

***Please note that all changes requested above will become effective on the 1st of the month following receipt of a signed form.**

I AUTHORIZE:

- Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits;
- Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and
- Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled.

When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Member's Signature _____ **Date**(y/m/d) _____

Protecting your personal information The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.