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 enroling 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

Class	Number Required
______	________________
______	________________
______	________________

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**