

Salary change request



Group no. _____ Firm no. _____ Firm name: _____

Certificate no.	Plan member name	New monthly salary	Effective date of change
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

Plan administrator signature		Date signed	DD / MM / YYYY
------------------------------	--	-------------	----------------

All changes are subject to the terms of the Group Contract(s) and any applicable legislation.
 Reminder: Disability insurance is based on declared monthly income. Confirmation of income, deemed satisfactory by the insurer, will be required at the time of claim. This usually consists of the last two T1 General Income Tax returns. Premium refunds will not be issued for any discrepancies.