

## Group Benefits Salary Change Request

### Section A-Plan Sponsor Information

Company Name	Firm Number
Plan Administrator/Authorized Signature	Date Signed (dd/mm/yyyy)

### Section B- Plan Member Information

	Employee Name	Salary Effective Date (dd/mm/yyyy)	Current Salary	New Annual Salary
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

- All changes are subject to the terms of the group contract and any applicable legislation.
- 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.
- Refunds will not be issued for any discrepancies.

**For Kechnie Office Use Only:**

Date Received: \_\_\_\_\_ Date Processed: \_\_\_\_\_ Adjudicator Initials: \_\_\_\_\_