THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE

For GWL Head Office Use Only

GWL Certificate Number

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 7 are to be completed by the plan member.

1. Plan Sponsor Section

This section is to be completed by the plan administrator.

Please note the policy waiting period will be applied to the eligible date of employment.

Plan number: _____ Division number: _____ Benefit class: _____

Plan sponsor: _____

Plan member ID: _____ Cost centre (if applicable): _____

Eligible date of employment: Month _____ Day _____ Year _____

Occupation: _____ Earnings: $ _____ per ❍ year ❍ month ❍ week ❍ hour

Plan member province of residence: _____ Plan member province of employment: _____

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

Plan member name (print): _____
last name first name middle initial

Gender: ❍ Male ❍ Female Date of birth: Month _____ Day _____ Year _____

Plan member mailing address:

Street address: _____

City: _____ Province: _____ Postal code: _____

Do you have a spouse (married, common-law or civil union spouse)? ❍ Yes ❍ No

Do you have dependent children, including full time students or disabled adults? ❍ Yes ❍ No

How many dependents in total, including spouse? _____

3. Refusal of Benefits

This section is to be completed by the plan member.

Cross outs and/or corrections in this section must be initialed.

Note: Health and/or dental coverage can only be refused if you and/or your dependents are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **I decline** to participate in:

Healthcare for ❍ myself and my dependents ❍ my dependents only

Dentalcare for ❍ myself and my dependents ❍ my dependents only

Spousal insurer's name: _____ Plan number: _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependents may be required to provide proof of insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. Beneficiary Designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original of this form will be required for a life claim.

Crossed out or corrected beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

Beneficiary's name(s) (last name, first name, middle initial)	Percent allocated	Date of birth month/day/year	Relationship to plan member

To be divided as follows: ❍ As per the percentages indicated above, or

❍ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable", below.

I hereby make the above beneficiary designation:

❍ **Revocable**, I may change this beneficiary designation at any time

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

CONTINUE ON REVERSE SIDE

To be completed by the plan administrator

Plan number: _____ Plan member name: _____ Plan member ID: _____

5. Dependent Information

This section is to be completed by the plan member.
Complete this section if the plan includes health and/or dental coverage and you have not refused such coverage for your dependents in section 3.
If there are more than four dependents, please attach a separate list. Please print clearly, in INK.

Spouse Information

last name | first name | middle initial

Date of birth (month/day/year)

Gender Male ○ Female ○

What group benefits coverage does your spouse have through his/her employer?

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
○	○	○	○	○	○	○	○	○	○	○	○

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

dependent Information

last name	first name	middle initial	Date of birth (month / day / year)	Gender Male	Gender Female	Full time student Yes	Disabled dependent Yes
				○	○	○	○
				○	○	○	○
				○	○	○	○
				○	○	○	○

6. Privacy

This section explains Great-West Life's commitment to privacy.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life),** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to determine your eligibility for coverage, and to administer the plan, including investigating and assessing claims, and creating and maintaining records concerning our relationship.

7. Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

Authorizations and Declarations

I hereby apply for coverage under the group benefits plan issued by Great-West Life.

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorizations and 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.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: _____ **Date:** _____

Clear