

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.

Plan number: \_\_\_\_\_ Division number: \_\_\_\_\_ Benefit class: \_\_\_\_\_

Plan sponsor: \_\_\_\_\_

Plan member ID: \_\_\_\_\_ Cost centre (if applicable): \_\_\_\_\_

Eligible date of employment: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Effective date of coverage: 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 dependant children, including full time students or disabled adults?  Yes  No

How many dependants in total, including spouse? \_\_\_\_\_

## 3. Refusal of Benefits

This section is to be completed by the plan member.

**Note:** Health and/or dental coverage can only be refused if you and/or your dependants 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 dependants  my dependants only

Dentalcare for  myself and my dependants  my dependants 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 dependants 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 beneficiary designations must be initialed.

Please print clearly in INK.

### Beneficiary Designation

Beneficiary's name(s)	Percent allocated	Relationship to plan member
last name first name middle initial	_____	_____
last name first name middle initial	_____	_____
last name first name middle initial	_____	_____

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 Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box 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

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To be completed by the plan administrator

Plan number: \_\_\_\_\_ Plan member name: \_\_\_\_\_ Plan member ID: \_\_\_\_\_

### 5. Dependant 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 dependants in section 3. If there are more than four dependants, please attach a separate list. Please print clearly, in INK.**

#### Spouse Information

last name	first name	middle initial
<b>Date of birth</b> (month/day/year)		
<b>Gender</b>		
	Male	Female
	<input type="checkbox"/>	<input type="checkbox"/>

#### 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

#### Dependant Information

			Date of birth	Gender		Full time student	Disabled dependant
			month / day / year	Male	Female	Yes	Yes
last name	first name	middle initial	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
last name	first name	middle initial	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
last name	first name	middle initial	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
last name	first name	middle initial	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes 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.

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

I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information".

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 or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of the 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 Québec applicants:** I request that this form be in English.  
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: \_\_\_\_\_ Date: \_\_\_\_\_