THE Great-West Life ASSURANCE COMPANY

GROUP COVERAGE CHANGE FORM

For GWL Head Office Use Only

GWL Certificate Number

Please print clearly and complete both sides of this form, in INK. Sections 1 & 2 are to be completed by the plan administrator and sections 3 through 11 are to be completed by the plan member, for applicable changes. Attach a copy to the plan member's application and send the **original** to The Great-West Life Assurance Company. For self-administered plans, GroupNet clients who maintain their own plan member's records and *ClienTEL* administered plans: attach this form to the plan member's application.

1. General Enrollment Information

Plan sponsor: _____ Plan number: _____ Division number: _____

Plan member name: _____ Plan member ID: _____
last name first name middle initial

2. Reinstatement

This information will be used to re-enroll the plan member in the group benefits plan.

Plan member returned to work on: Month _____ Day _____ Year _____

Reason for reinstatement (E.g., return from leave of absence, return from lay-off) _____

_____

3. Refusal of Benefits

Health, dental and/or vision coverage may only be removed if you have duplicate group benefits through your spouse's employer.

In addition, vision coverage may only be removed if it is separate from healthcare in your group benefits plan.

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

Visioncare for ◯ myself and my dependants ◯ my dependants only

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

Spousal insurer's name: _____ Plan number: _____

Effective date: _____

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 may be required to provide proof of your insurability acceptable to Great-West Life to be covered. If you are approved, dental benefits, if applicable, may be limited.

Please see your plan administrator for details.

4. Addition of Group Health, Dental and/or Vision Benefits

You may apply to be enrolled for group coverage, if your spouse has lost group benefits coverage through his/her employer.

Effective date of loss of coverage through spousal plan: Month _____ Day _____ Year _____

Indicate the benefit(s) no longer covered under the spousal plan:

◯ Healthcare

◯ Dentalcare

◯ Visioncare

5. Dependant Information Change

This section must be completed if you are adding or deleting a dependant, or updating dependant information.
If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Effective date of change: Month _____ Day _____ Year _____

To: ◯ Single coverage ◯ Family coverage

Reason: ◯ Birth of child ◯ Divorced/legal separation ◯ Marriage ◯ Cohabitation Date of marriage/cohabitation: Month _____ Day _____ Year _____

◯ Other (please specify) _____

Spouse Information

Add ◯ **Change** ◯ **Delete** ◯

_____
last name first name middle initial

Date of birth (month/day/year) _____

Gender Male ◯ Female ◯

What group benefits coverage does your spouse have through an employer?

HEALTHCARE → Does this include prescription drug coverage?

Single ◯ Family ◯ Waived ◯ None ◯ Yes ◯ No ◯

DENTALCARE Single ◯ Family ◯ Waived ◯ None ◯

VISIONCARE Single ◯ Family ◯ Waived ◯ None ◯

Dependant Information

Add	Change	Delete	last name	first name	middle initial	Date of birth month/day/year	Gender Male	Gender Female	Full time student Yes	Full time student No	Disabled dependant Yes	Disabled dependant No
◯	◯	◯					◯	◯	◯	◯	◯	◯
◯	◯	◯					◯	◯	◯	◯	◯	◯
◯	◯	◯					◯	◯	◯	◯	◯	◯
◯	◯	◯					◯	◯	◯	◯	◯	◯

To be completed by the plan administrator

Plan number: _____ Plan member name: _____

6. Plan Member Name Change

From: _____ To: _____
last name first name middle initial last name first name middle initial

7. Beneficiary Designation Change

This section must be completed to change the designated beneficiary or beneficiaries for your life benefits.

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

Please print clearly, in INK.

Beneficiary Designation

I hereby make the following change(s) to my previous beneficiary appointment:

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	_____	_____

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below.

You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

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 circle marked "Revocable", below.

I hereby make the above beneficiary designation: ◯ **Revocable** ◯ **Irrevocable**

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.

8. Current Beneficiary Name Change

From: _____ To: _____
last name first name middle initial last name first name middle initial

Relationship to plan member: _____

9. Opting Out of all Group Benefits

You may opt out of your group benefits plan, if your coverage is non-compulsory.

Opting out of all group benefits - for non-compulsory plans only.

◯ I understand the group benefits plan offered to me, but **I decline** to participate.
If at any time in the future you wish to join the group benefits plan, you and your dependants will have to provide proof of insurability, acceptable to Great-West Life to be covered. If approved, dental benefits, if applicable, may be limited.

Effective date: _____

Please see your plan administrator for details.

10. Privacy

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

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West),** we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West or the offices of an organization authorized by Great-West. We limit access to information in your file to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefits plan.

11. Authorizations and Declarations

This section must be signed by the plan member.

Authorizations and Declarations

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

I authorize:

- My plan sponsor to deduct from my pay and remit to Great-West the plan member contribution required under the group benefits plan, if applicable;
- Great-West to use my social insurance number to administer my coverage and benefits under the group benefits plan, when required;
- Great-West, any healthcare provider, my plan administrator, other insurance companies, or benefit providers working with Great-West to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefits plan.

If applying for coverage for my spouse and/or dependants, 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 Québec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

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

Plan administrator signature: _____ Date: _____