

GROUP COVERAGE CHANGE FORM

For GWL Head Office Use Only	y
GWL Certificate Number	Π

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. The plan administrator should keep a copy of the completed form for their records and send the **original** to The Great-West Life Assurance Company. For self-administered plans, GroupNet clients who maintain their own plan members' records and *ClienTEL* administered plans: the plan administrator should attach this form to the plan member's application.

1.	General Enrollment Information			Plan number: Division number:								
				Plan sponsor:								
				Plan member name:		first name	middle initi		n membe	er ID:		
				last name								
2.		stateme	ent rill be used to	Plan member returned to work on	: Mor	nth	Da	ay		Year		
	re-enroll		member in the	Reason for reinstatement (E.g., return from leave of absence, return from lay-off)								
	Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by during 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: Effective date of change: Month Day Year 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 provide provided insurability acceptable to Great-West Life to be covered. If you are approved, coverage for the benefits may be limited. Please see your plan administrator for details. You may apply to be enrolled for group coverage if your spouse has lost group benefits coverage through his/her employed.								uch coverage ovide proof of ge for denta			
4. Addition of Group Health and/or Dental Benefits 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								ar				
5.	This sec	tion must		Change ou are adding or deleting a dependant, or lants, please attach a separate list. Ple								
Effec	tive date	of chan	ige: Month		Day			Yea	r			
То:			erage –		, _			_				
Reas				○ Marriage ○ Cohabitation □	ate of n	narriage/coha	bitation: Mor	nth		Day	Year	
Spou	ise Infori				What	aroup bonofi	te coverage	doos	VOUR SD	ouso havo ti	nrough his/hei	
	Change				emplo	yer?					_	
0	0	_	last name	first name middle initial		HEALTHCARE					ONCARE nily Waived None	
Date	of birth		day/year)	Gender	Single	O O	O O		Valved INC		`	
				Male Female	Where a	applicable, benefit	payments will be	e coordin	ated betwe	en this plan and	your spouse's plan	
	ndant In		<u>on</u>			Date of	birth	Ge	nder	Full time	Disabled	
Add	Change	Delete				month/day	//year	Male	Female	student Yes	dependant Yes	
0	0	0						0	0	0	0	
_			ast name	first name middl	e initial			_	-			
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		ī	ast name	first name middl	e initial							

Filan number: Plan member name: Plan member name: Plan member D. Filan Member Name Change 7. Beneficiary Designation Change This section must be considered to form the designation of the designation	To be completed by the plan administrator									
The Beneficiary The sending must be completed to change the designation of the first name (s) Beneficiary besignation Change This section must be completed to change the designation of the designation	Plan	number:	Plan member name):		Plan r	nember ID:			
The Beneficiary The sending must be completed to change the designation of the first name (s) Beneficiary besignation Change This section must be completed to change the designation of the designation	6	Plan Member Name	From:		To:					
Percent Result of the designation Change This section must be completed to change the designation of the form will be required for a life claim. Crossed out beneficiary of the form will be required for a life claim. Crossed out beneficiary designation a must be initiated. Please print clearly, in INK. Note: Where Quelen law applies and you have designated any print a upon revision of the print will be the print of the	0.			first name		name	first name	middle initial		
Beneficiary's name(s) Beneficiary's name(s) Beneficiary is name(s) Benefici	7.	Beneficiary								
This section must be completed to change the designated berelitianly or beneficiaries for the designated berelitianly or beneficiaries for the designated berelitianly or beneficiaries for the designation of the form with the required for a life claim. Croseed out beneficiary designations must be initiated. Please print clearly, in INK.		Designation Change								
Security		to change the designated	Beneficiary's name(s)							
Islant name first name middle initial			last name	first nam	e middle initial					
Islame		•	last name	first nam	e middle initial					
Please print clearly, in NK. Please print clearly, in NK. To be divided as follows: As per the percentages indicated above, or one question and the equal shares to the survivor(s). When we designated not any time upon notice to Great-West Life. If you wish to make the beneficiary designation was one and any time upon notice to Great-West Life. If you wish to make the beneficiary designation or make certain changes to your coverage under the plan without the written consent of the beneficiary please complete form #M64348 Bit. Note: Where Quebec law apples and you have designated your married spouse or civil union spouse as beneficiary, beginning the designation at any time. If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustered ministrator by completing form #M6426 Bit. This appointment may not be suitable for all purposes. If you are designating a trustered ministrator, we recommend you consult with a legal advisor, and with any proposed trustered ministrator, we recommend you consult with a legal advisor, and with any proposed trustered ministrator, we recommend you consult with a legal advisor, and with any proposed trustered ministrator, we recommend you consult with a legal advisor, and with any proposed trustered ministrator, we recommend you consult with a legal advisor, and with any proposed trustered ministrator on the proposed proposed in surface and the proposed pending and assessing claims in the future you wish to join the group benefits plan, you and your dependants will have to provide pendi		designations must be	last name	first nam	e middle initial					
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 you coverage under the plan without the written consent of the beneficiary pleasage of the plan of the plan without the written consent of the beneficiary pleasage of the plan of the		initialed.	To be divided as follow	s: O As per the per	centages indicated al	bove, or				
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 under the plan without the written consent of the beneficiary please place for meaning and you have designated your married spouse or civil union spouse as beneficiary, the designation will be inverseable unless you check the circle marked "Revocable", below. I hereby make the above beneficiary designation at any time. I designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 Bit. This appointment may not be suitable for all purposes. If you are designating a trustee/administrator. From: To:		Please print clearly, in INK.		O In equal share	s to the survivor(s)					
trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes. If you are designating a trustee/administrator. 8. Current Beneficiary Name Change Complete if a current beneficiary has had a legal drivage of name. 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 and the future you wish to join the group benefits plan, if your overage is non-compulsory. This section explains Great-West Life's commitment to privacy. This section explains Great-West Life's commitment to privacy. This section explains are committened to privacy. When you apply for coverage, we establish a confidential file that contains your personal information authorized by Great-West Life to previous of caread. Well limit accepts the fire privacy. When you apply for coverage, we establish a confidential file that contains your personal information routside Canada. We limit access to personal information in your file to great-West Life start or personal authorized by Great-West Life or the offices of an organizan unthorized by Great-West Life your personal information in your file to great-West Life start or persons authorized by Great-West Life start or outside Canada. We collect, use and disclose the personal information in your file to great-West Life start or persons authorized by Great-West Life with committee the plan, including investigating and assessing claims, and peculiar in in in in the part of the personal information in your file to great-West Life start or personal information in which we provide your eligibility for coverage and to administer the plan, including investigating and assessing claims, and reating and maintaining records concerning our relationship. Authorizations and Declarations 11			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:							
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 Complete if a current beneficiary hash add a legal change of name. 9. Opting Out of all Group Benefits You may opt out of your group benefits plan, if your coverage is non-compulsory. 9. Opting Out of all group benefits You may opt out of your group benefits plan, if your coverage is non-compulsory. 9. Opting Out of all group benefits have been benefit by the plan 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. 10. Privacy This section explains Great-West Life sommitment to privacy. 11. Authorizations and Declarations This section must be signed and dated in INK by the plan member. 12. Authorizations and Declarations This section must be signed and dated in INK by the plan member. 13. Authorizations and Declarations This factor is the plan member of the part of the par			If you are designating	g a trustee/adminis	trator, we recommen	•				
Last name	8.	Current Beneficiary								
Protecting Your proup benefits Source Source		=	last name	first name	middle initial last	name	first name	middle initial		
Group Benefits You may opt out of your group benefits plan, if your coverage is non-compulsory. 10. Privacy This section explains Great-West Life to the Coverage of privacy. This section explains Great-West Life sommitment to privacy. This section must be signed and dated in INK by the plan member. This section must be signed and dated in INK by the plan member. This section must be signed and dated in INK by the plan member. This section must be signed and dated in INK by the plan included 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 to use my social insurance number for tax reporting purposes and as an identification number where it is required to here administration of the plan; Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required to here administration of the plan; Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required to here administration of the plan; Great-West Life to everage and to administer the plan. If applying for coverage for my spouse and/or dependant			Relationship to plan me	ember:						
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Protecting Your payable part your coverage is non-compulsory. 10. Privacy This section explains Great-West Life's commitment to privacy. Protecting Your Personal Information At The Great-West Life's commitment to privacy. Protecting Your Personal Information At The Great-West Life's commitment to privacy. Protecting Your Personal Information At The 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 by sending a request in writing to Great-West Life. Great-West Life may use service providers located 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. Authorizations and Declarations This section must be signed and dated in INK by the plan member. Authorizations and Declarations This section must be signed and dated in INK by the plan member. Authorizations and Declarations Thereby apply for coverage under the group benefits plan issued by Great-West Life. I authorize: Must be a coverage to the deduct from my pay and remit to Great-West Life to plan; 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 to use my social insuran		. •	O I understand the gr	oup benefits plan of	ered to me, but I dec	cline to participat	e.			
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For Quebec applicants: I request that this form be in English. Je demande que ce formulaire me soit remis en anglais.			original.	.,	•			as valid as the		
			For Quebec applicants: I request that this form be in English.							
			Plan member signatu	·		ŭ	Date:			

Date: _

Plan administrator signature: _

Page 2 of 2