

# APPLICATION FOR OPTIONAL GROUP AD&D COVERAGE

Please print clearly and complete this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 6 are to be completed by the plan member.

<p><b>1. Plan Sponsor Section</b></p> <p>This section is to be completed by the plan administrator.</p>	<p>Plan number: _____ Division number: _____ Benefit class: _____</p> <p>Plan sponsor: _____</p> <p>Plan member ID: _____ Cost centre (if applicable): _____</p> <p>Effective date of coverage: Month _____ Day _____ Year _____</p> <p>Plan member province of residence: _____ Plan member province of employment: _____</p>
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<p><b>2. Plan Member Information</b></p> <p>This section is to be completed by the plan member.</p> <p><b>Please print clearly, in INK.</b></p>	<p>Plan member name (print): _____  <small style="margin-left: 100px;">last name</small> <small style="margin-left: 100px;">first name</small> <small style="margin-left: 100px;">middle initial</small></p> <p>Gender: <input type="radio"/> Male <input type="radio"/> Female Date of birth: Month _____ Day _____ Year _____</p> <p>Plan member mailing address:</p> <p>Street address: _____</p> <p>City: _____ Province: _____ Postal code: _____</p>
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<p><b>3. AD&amp;D Benefit Amount</b></p> <p>This section is to be completed by the plan member.</p>	<p><b>Coverage Amount Elected</b></p> <p>Current Optional AD&amp;D amount: \$ _____          (if no current amount, please indicate that with a zero)</p> <p>Total Optional AD&amp;D amount being applied for: \$ _____          (current plus additional amount being applied for)</p> <p style="text-align: right;"><input type="radio"/> Employee only coverage  <input type="radio"/> Employee and dependant coverage</p>
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<p><b>4. Beneficiary Designation</b></p> <p>This section is to be completed by the plan member.</p> <p>This section must be completed to designate a beneficiary for your life benefits, if applicable.</p> <p><b>The original of this form will be required for a life claim.</b></p> <p><b>Crossed out beneficiary designations must be initialed.</b></p> <p><b>Please print clearly, in INK.</b></p>	<p><b>Beneficiary Designation</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Beneficiary's name(s)</th> <th style="width: 10%;">Percent allocated</th> <th style="width: 20%;">Relationship to plan member</th> </tr> </thead> <tbody> <tr> <td>last name _____ first name _____ middle initial _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>last name _____ first name _____ middle initial _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>last name _____ first name _____ middle initial _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>To be divided as follows: <input type="radio"/> As per the percentages indicated above, or  <input type="radio"/> In equal shares to the survivor(s)</p> <p>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.</p> <p><b>Note:</b> 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.</p> <p><b>I hereby make the above beneficiary designation:</b></p> <p><input type="radio"/> <b>Revocable</b>, I may change this beneficiary designation at any time</p> <p>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.</p> <p><b>If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.</b></p>	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 _____	_____	_____
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 _____	_____	_____											

<p><b>5. Privacy</b></p> <p>This section explains Great-West Life's commitment to privacy.</p>	<p><b>Protecting Your Personal Information</b></p> <p>At <b>The Great-West Life Assurance Company (Great-West Life)</b>, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. 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. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.</p>
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<p><b>6. Authorizations and Declarations</b></p> <p>This section must be signed and dated in INK by the plan member.</p>	<p><b>Authorizations and Declarations</b></p> <p>I hereby apply for coverage under the group benefits plan issued by Great-West Life.</p> <p>I authorize:</p> <ul style="list-style-type: none"> <li>• my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;</li> <li>• 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;</li> <li>• 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.</li> </ul> <p>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 <u>Authorizations and Declarations</u> section is as valid as the original.</p> <p>I certify that the information given is true, correct and complete to the best of my knowledge.</p> <p><b>For Quebec applicants:</b> I request that this form be in English.          Je demande que ce formulaire me soit remis en anglais.</p> <p style="text-align: right;"><b>Plan member signature:</b> _____ <b>Date:</b> _____</p>
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