THE Great-West Life ASSURANCE COMPANY

GROUPNET 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. 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.

1. General Enrollment Information

Plan number: _____ Division number: _____

Plan sponsor: _____

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

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 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: _____

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 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. Addition of Group Health and/or Dental 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

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 ❍ Divorce ❍ 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 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.

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	Disabled dependant Yes
❍	❍	❍					❍	❍	❍	❍
❍	❍	❍					❍	❍	❍	❍
❍	❍	❍					❍	❍	❍	❍
❍	❍	❍					❍	❍	❍	❍

CONTINUE ON REVERSE SIDE

M6109(GN)-11/07

To be completed by the plan administrator

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

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 of this form will be required for a life claim.

Crossed out beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Beneficiary's name(s)	Percent allocated	Date of birth month/day/year	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 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.

8. Current Beneficiary Name Change

Complete if a current beneficiary has had a legal change of name.

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: Month _____ Day _____ Year _____

Please see your plan administrator for details.

10. 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.

11. 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 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 Quebec 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: _____

Clear