GROUP COVERAGE CHANGE FORM

For Canada Life Head Office Use Only
Canada Life 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 13 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 Canada Life Assurance Company. For self-administered plans and GroupNet clients who maintain their own plan member's records the plan administrator should attach this form to the plan member's application.

1. General enrolment information

Plan number: _____ Division number: _____ Plan member ID: _____

Plan sponsor: _____

Plan member name (print): _____
last name first name middle initial

2. Reinstatement

This information will be used to re-enrol 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

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 Canada 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 their 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 mm/dd/yy	Gender
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other

What group benefits coverage does your spouse have through their employer?
Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

	HEALTHCARE				DENTALCARE				VISIONCARE			
	Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dependant Information

Add	Change	Delete	Last name	First name	Middle Initial	Date of birth mm/dd/yy	Gender	Full time student	Disabled dependant
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐

CONTINUED ON NEXT PAGE

M6190-1/20

6. Plan member name change

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

7. Beneficiary designation

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.

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

Primary Beneficiary | 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 percentage indicated above, or
☐ In equal shares to the survivor(s)

8. Contingent beneficiary designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section.

If there are no surviving benficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Contingent Beneficiary | 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 percentage indicated above, or
☐ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Canada 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 box marked "Revocable", below.

I hereby make the above beneficiary designation:

☐ **Revocable, I may change this beneficiary designation at any time**

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Canada Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. **Before designating a trust, you should seek legal advice.**

9. Trustee appointment

You may wish to appoint a trustee/administrator by completing this section

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

Please print clearly, in INK.

DO NOT COMPLETE THIS SECTION IF YOU ARE A QUEBEC RESIDENT

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing this form. 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.

Do not complete this section if you have made another trustee/administrator appointment.

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release The Canada Life Assurance Company from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in trust.

_____ _____ _____ _____
Trustee last name first name middle initial Relationship to plan member

10. 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: _____

11. 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 Canada 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.

CONTINUED ON NEXT PAGE

12. Privacy

This section explains Canada Life's commitment to privacy.

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada 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 Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

13. 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 Canada Life.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

- my plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable;
- Canada 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;
- Canada 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 Canada Life or the above to exchange personal information, when relevant and 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 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 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