

**TO BE COMPLETED BY THE PLAN ADMINISTRATOR**

Policy #: \_\_\_\_\_ Division #: \_\_\_\_\_ Benefit Class: \_\_\_\_\_ Employee I.D. (if applicable) \_\_\_\_\_  
 Company Name: \_\_\_\_\_  
 Eligible Date of Employment / Date of Full-Time Employment: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Occupation \_\_\_\_\_ Earnings: \$ \_\_\_\_\_ per  Year  Month  Week  
 Province of Residence: \_\_\_\_\_ Province of Employment: \_\_\_\_\_

**EMPLOYEE INFORMATION**

Full Name (print): Last: \_\_\_\_\_ First: \_\_\_\_\_  
 Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Gender:  Male  Female  
 Employee's Mailing Address: \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**DEPENDANT INFORMATION**

Do you have dependants?  Yes  No # of dependants \_\_\_\_\_  
 Do you have a spouse/common-law spouse?  Yes  No  
 If "Yes" to either of the above questions, **complete the dependant information on the reverse of this page.**

**WAIVER OF GROUP HEALTH AND/OR DENTAL COVERAGE**

\*NOTE: Coverage can only be waived, if you and/or your dependants are covered by a spousal plan.  
 I understand the group insurance plan offered to me, but I **DECLINE** to participate in:  
 Healthcare for:  myself and my dependants  my dependants only Spouse's "Other Insurer" \_\_\_\_\_  
 Dentalcare for:  myself and my dependants  my dependants only Spouse's Policy Number \_\_\_\_\_  
 If you lose spousal coverage you must apply for coverage within 31 days of loss. If you do not apply within 31 days you will have to provide proof of your insurability to be covered. When you are approved, dental benefits, if applicable, will be limited in the first two years of coverage.

**BENEFICIARY DESIGNATION**

Beneficiary's Name (First Name, Last Name) \_\_\_\_\_ Relationship to Employee \_\_\_\_\_  
 You are responsible to ensure the beneficiary designation is complete. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.  
 NOTE: Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable.  
 I hereby make the designation:  Revocable  Irrevocable

**TRUSTEE CLAUSE:** If appointing a minor beneficiary, you may wish to complete this Trustee Clause.  
 I hereby nominate and appoint the following trustee to receive and disburse any moneys payable under the group policy to my beneficiary(ies) during minority, and any payments made to this trustee will release THE GREAT-WEST LIFE ASSURANCE COMPANY of any further liability.  
 Trustee's Name (First Name, Last Name) \_\_\_\_\_ Relationship to Employee \_\_\_\_\_

**AUTHORIZATIONS AND DECLARATIONS**

**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 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.**

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 Québec applicants:** I request that this form be in English.  
 Je demande que ce formulaire me soit remis en anglais.

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

Policy #: \_\_\_\_\_

Employee Name: \_\_\_\_\_

**DEPENDANT INFORMATION**

**SPOUSE INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Indicate your spouse's coverage with their employer: Health:  Single  Family  Waived  None

Dental:  Single  Family  Waived  None

Vision:  Single  Family  Waived  None

**OTHER DEPENDANT INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  Male  Female

Disabled?  Yes  No Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Student?  Yes  No

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First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  Male  Female

Disabled?  Yes  No Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Student?  Yes  No

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First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  Male  Female

Disabled?  Yes  No Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Student?  Yes  No

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First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  Male  Female

Disabled?  Yes  No Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Student?  Yes  No

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