THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR OPTIONAL GROUP AD&D COVERAGE

For GWL Head Office Use Only
GWL Certificate Number

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.

1. Plan Sponsor Section

This section is to be completed by the plan administrator.

Plan number: _____ Division number: _____ Benefit class: _____

Plan sponsor: _____

Plan member ID: _____ Cost centre (if applicable): _____

Effective date of coverage: Month _____ Day _____ Year _____

Plan member province of residence: _____ Plan member province of employment: _____

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in ink.

Plan member name (print): _____
Last name First name Middle initial

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other Date of birth: Month _____ Day _____ Year _____

Plan member mailing address:

Street address: _____

City: _____ Province: _____ Postal code: _____

3. AD&D Benefit Amount

This section is to be completed by the plan member.

Coverage Amount Elected

Current Optional AD&D amount:
(if no current amount, please indicate that with a zero) $ _____

Total Optional AD&D amount being applied for:
(current plus additional amount being applied for) $ _____

☐ Employee only coverage
☐ Employee and dependant coverage

4. 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):

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 _____	_____	_____

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 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 Great-West 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.

For All Other Applicants - 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. **Before designating a trust, you should seek legal advice.**

5. Privacy

This section explains Great-West Life's commitment to privacy.

Protecting Your Personal Information

At **The Great-West Life Assurance Company**, 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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

6. Authorizations and Declarations

This section must be signed and dated in **ink** by the plan member.

I hereby apply for the changes in coverage under the group benefits plan issued by Great-West Life.
I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information".
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 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 Québec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: _____ **Date:** _____

Clear