THE Great-West Life ASSURANCE COMPANY

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 8 are to be completed by the plan member, for applicable changes. For self-administered plans and GroupNet clients who maintain their own plan member's records, attach this form to the plan member's original application form.

1. General Enrollment Information

Plan sponsor: **UNIVERSITY OF ALBERTA POSTDOCTORAL FELLOWS**

Plan number: **155419** Plan member ID: _____

Plan member name: _____
last name first name middle initial

2. Dependant Information Change

This section must be completed if you are adding or deleting dependants.

Effective date of change: Month _____ Day _____ Year _____

Change to: ☐ Single coverage ☐ Family coverage

Reason: ☐ Marriage ☐ Cohabitation Date of marriage/cohabitation: Month _____ Day _____ Year _____

☐ Divorced/legal separation ☐ Birth of child(1st dependant)

☐ Other (please specify): _____

3. Plan Member Name Change

From: _____
last name first name middle initial

To: _____
last name first name middle initial

4. Refusal of Dependant Benefits

Health and/or dental coverage may only be removed if your dependants have 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

Note: Coverage can only be refused if your dependants are covered by duplicate group benefits through your spouse's employer.

Spousal insurer's name: _____ Plan number: _____

Effective date: _____

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 may be required to provide proof of your insurability acceptable to Great-West Life to be covered. If your dependants are approved, dental benefits, if applicable, may be limited.
Please see your plan administrator for details.

5. Addition of Group Health and/or Dental Benefits

You may apply to be enrolled for dependant 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

6. 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 unpaid leave of absence, return from lay-off) _____

_____

PLEASE SEE BACK FOR REQUIRED SIGNATURE AND DATE

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To be completed by the plan administrator

Plan number: **155419** Plan member name: _____

7. Privacy

This section explains Great-West'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.

8. Authorizations and Declarations

This section must be signed 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:** _____

Plan administrator's signature: _____ Date: _____

PLEASE RETURN ORIGINAL SIGNED COPY TO THE POSTDOCTORAL FELLOWS OFFICE, 1-03 SOUTH ACADEMIC BUILDING, UNIVERSITY OF ALBERTA