THE Great-West Life ASSURANCE COMPANY

FAX NO.: (204) 946-8972

EMPLOYEE CHANGE FORM

If beneficiary information has been completed, please send the original to:

The Great-West Life Assurance Company
P.O. Box 6000
Winnipeg, Manitoba R3C 3A5

Policyholder's Name: _____ Policy #_____ Division #_____

Employee's Name _____ Employee I.D. _____

CHANGE OF BENEFICIARY

I hereby make the following change(s) to my previous beneficiary appointment:

_____ _____
Beneficiary's Name (First Name, Last Name) Relationship

_____ _____
Beneficiary's Name (First Name, Last Name) Relationship

_____ _____
Beneficiary's Name (First Name, Last Name) Relationship

You are responsible to ensure the beneficiary designation is complete. Where Quebec Law applies, a spouse beneficiary is irrevocable unless you make the designation revocable

I hereby make the designation: ☐ Revocable ☐ Irrevocable

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.

To be divided as follows: (if applicable) ☐ In equal shares to the survivor(s)

☐ Other (please specify)_____

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 this 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

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.

_____ _____
Employee's Signature Date

SEE REVERSE

Policy #: _____ Employee Name: _____

WAIVER OF ALL GROUP BENEFITS - For Non-Compulsory Plans Only

☐ I understand the group insurance plan offered to me, but I decline to participate.

If at any time in the future you wish to join the plan, you and your dependants will have to provide proof of insurability to be covered. When approved, dental benefits, if applicable, will be limited in the first two years of coverage.

Please consult your Plan Administrator for more details.

_____ _____

Employee's Signature Date

WAIVER OF GROUP HEALTH AND/OR DENTAL COVERAGE

I understand the group insurance plan 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 waived if you and/or your dependants are covered by a spousal plan. Please provide the following detail concerning your spouse's plan:

Other Insurer's Name: _____ Policy # _____ Effective Date _____

If you lose spousal coverage you must apply for coverage within 31 days of loss. If you do not apply within 31 days, you and your dependants will have to provide proof of insurability to be covered. When approved, dental benefits, if applicable, will be limited in the first two years of coverage.

CHANGE IN DEPENDANT INFORMATION

Effective Date of Change _____

SPOUSE INFORMATION

ADD	DELETE	First Name, Last Name	GENDER M	GENDER F	DATE OF BIRTH MMM/DD/YYYY
☐	☐	_____	☐	☐	_____

Indicate your spouse's coverage with their employer:

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

CHILDREN INFORMATION

ADD	DELETE	First Name, Last Name	GENDER M	GENDER F	DATE OF BIRTH MMM/DD/YYYY	FULL TIME STUDENT	DIS-ABLED
☐	☐	_____	☐	☐	_____	☐	☐
☐	☐	_____	☐	☐	_____	☐	☐
☐	☐	_____	☐	☐	_____	☐	☐
☐	☐	_____	☐	☐	_____	☐	☐

EMPLOYEE NAME CHANGE

From: (First Name, Last Name) _____ To: (First Name, Last Name) _____

STATUS CHANGE

Effective Date of Change: _____

To: ☐ Single Coverage ☐ Family Coverage

Reason: ☐ Marriage/Cohabitation Date of Marriage/Cohabitation _____

☐ Other (please specify) _____

REINSTATEMENT

The Employee returned to work on _____
(MMM/DD/YYYY)

_____ _____

Employee's Signature Date

_____ _____

Employer's Signature Date

CLEAR