

# 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

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

Other (please specify) \_\_\_\_\_

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.

## 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 Great-West, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West or the offices of an organization authorized by Great-West. We limit access to information in your file to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefit 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 DATE OF BIRTH  
M F 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 DATE OF BIRTH FULL TIME DIS-  
M F MMM/DD/YYYY STUDENT ABLED

\_\_\_\_\_  
First Name, Last Name

\_\_\_\_\_  
First Name, Last Name

\_\_\_\_\_  
First Name, Last Name

\_\_\_\_\_  
First Name, Last Name

\_\_\_\_\_  
First Name, Last Name

**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