THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE
EMPLOYEE BASIC LIFE INSURANCE, EMPLOYEE OPTIONAL LIFE INSURANCE, OPTIONAL DEPENDENT LIFE INSURANCE

Please print clearly and complete both sides of 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 employee. Return to Pension & Benefit Advisory Services, 2-60 University Terrace.

1. Employer Section
This section is to be completed by the plan administrator.

ACADEMIC POLICY #: ☐ **335040** (Basic Life) ☐ **335041** (Optional Employee Life)
☐ **335040** (Optional Dependent Life)

CLASS: _____

Employer name: UNIVERSITY OF ALBERTA

Date of eligibility: Month _____ Day _____ Year _____

Employee Basic Life
This benefit is mandatory.

$100,000

2. Employee Section
This section is to be completed by the employee.

Please print clearly, in INK.

Employee name _____
last name first name middle initial

Employee ID: _____

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

Do you have a spouse? ☐ Yes ☐ No

Do you have dependent children? ☐ Yes ☐ No

3. Employee Optional Life Insurance and Optional Dependent Life Insurance

Optional Employee Life

☐ I wish to apply for _____ units (1-50) of employee optional life (each unit is equal to $10,000 of coverage).

Medical evidence is not required if applying within 90 days of date of eligibility for any amount listed up to and including $180,000 (18 units). If you wish to apply for amounts exceeding this, up to $500,000, please complete the Evidence of Insurability Coverage Detail form available from Pension & Benefit Advisory Services.

Within the past 12 months have you smoked or used cigarettes, marijuana, hashish, cigars, pipe cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts, or tobacco, or nicotine in any other form.
☐ Yes ☐ No

☐ I do not wish to apply for this benefit.

Optional Dependent Life

☐ I wish to apply for optional dependent life of $15,000 on my spouse and $5,000 on each child.

☐ I do not wish to apply for this benefit.

M6191(335040)-5/16

4. Beneficiary Appointment - Employee Basic Life and Employee Optional Life Insurance

The original or copy of this original form will be required for a Life claim.

Please print clearly, in INK.

I hereby appoint the beneficiary of my insurance to be paid in the event of my death. Where I have named more than one beneficiary, each is allocated an equal share of my insurance unless I have indicated otherwise.

Primary Beneficiary Employee Basic Life	Percent allocated	Relationship to plan member	Basic Life	Opt Life
last name first name middle initial			☐	☐
last name first name middle initial			☐	☐
last name first name middle initial			☐	☐
last name first name middle initial			☐	☐

Appointing Contingent Beneficiaries

If you wish to appoint a contingent beneficiary, in the event that there are no surviving beneficiaries at the time of your death, please complete this section.

Please print clearly, in INK.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Unless I specify otherwise, my contingent beneficiary will apply to all benefits for which I have coverage. I revoke all previous contingent beneficiary appointments.

Name (first, last)	Relationship to plan member	Percentage	Basic Life	Opt Life
			☐	☐
Name (first, last)	Relationship to plan member	Percentage	Basic Life	Opt Life
			☐	☐

MINOR CLAUSE - check (✓) if necessary

☐ TRUSTEE FOR CHILDREN

Full Name (please print) _____ Relationship to Life Insured _____

is hereby appointed Trustee to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED in this form who is a minor on the date such payment falls due.

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. Authorization and Declaration

This section must be signed by the employee.

I hereby apply for 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, 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.

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

Clear