GROUP COVERAGE CHANGE FORM

Please print clearly and complete both sides of this form, in INK. The plan administrator should attach the original form to the plan member's application. For self-administered plans and GroupNet clients who maintain their own plan member's records the plan administrator should attach this form to the plan member's application.

1. General enrolment information

Plan number: 168000 Division number: _____

Plan sponsor: Government of Newfoundland and Labrador

Plan member name (print): _____
last name first name middle initial

Date of Birth: Month _____ Day _____ Year _____

Member ID #: (found on drug card): _____ Employee #: (assigned by employer): _____

2. Benefit changes – mandatory healthcare benefits

Effective date of change: Month _____ Day _____ Year _____

☐ I wish to add/change healthcare coverage: ☐ Single* ☐ Family

***A change from Family to Single healthcare will automatically terminate coverage for all dependant's previously insured under this benefit.**

Reason for addition/change: ☐ Birth of Child ☐ Marriage (Please provide copy of marriage certificate) ☐ Divorce
☐ Cohabitation Date of Marriage/Cohabitation Month _____ Day _____ Year _____
☐ Previously Enroled With Single Health Only ☐ Loss of Spousal Coverage
☐ Other (please specify): _____

☐ I wish to waive healthcare coverage. You can waive Healthcare coverage only if your spouse is also an employee/retiree with the Government of Newfoundland & Labrador and s/he has **enroled in** family health coverage.

Spouse's Employer's Name: _____ Spouse's Member ID #: _____

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 and your dependants will be required to provide proof of insurability acceptable to Canada Life to be covered.

Please see your plan administrator for details.

3. Dependant information change

This section must be completed if you are adding or deleting a dependant, or updating dependant information.
If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Spouse Information

Add	Change	Delete	Last name	First name	Middle Initial	Date of birth mm/dd/yy	Gender
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other

What group benefits coverage does your spouse have through their employer?
Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

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

Dependant Information

Add	Change	Delete	Last name	First name	Middle Initial	Date of birth mm/dd/yy	Gender	Full time student	Functionally impaired dependant
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
☐	☐	☐					☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐

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4. Optional Benefits

This section to be completed by the Plan Member.

If you wish to apply for Optional benefits coverage offered under the Government of Newfoundland & Labrador benefits plan please indicate your choices below. If you wish to cancel Optional benefits coverage, please indicate in the space provided.

If evidence of insurability is required please complete the Evidence of Insurability Coverage Detail and Medical & Lifestyle Questionnaire, form M5995(GNLSA).

Optional Employee Life (Policy No. 168002)

***For a plan member who is covered as both an employee and as a spouse under the GNL policy the maximum amount of Optional Employee Life and Optional Spousal Life Insurance that can be applied for is $300,000 combined**.

☐ I wish to apply for Optional Employee Life coverage up to $100,000 and have completed the Declaration of Good Health or the M5995(GNLSA).
Amount: _____

☐ I wish to apply for Optional Employee Life coverage for an amount over $100,000 and have completed the M5995(GNLSA).

Existing amount: _____ New amount: _____ (can be purchased in units of $10,000)

Total Amount: _____ (maximum of $300,000)

☐ I wish to cancel Optional Employee Life coverage

Optional Spousal Life (Policy No. 168002)

***For a plan member who is covered as both an employee and as a spouse under the GNL policy the maximum amount of Optional Employee Life and Optional Spousal Life Insurance that can be applied for is $300,000 combined**.

☐ I wish to apply for Optional Spousal Life coverage up to $100,000 and have completed the Declaration of Good Health or the M5995(GNLSA).

Amount: _____

☐ I wish to apply for Optional Spousal Life coverage for an amount over $100,000 and have completed the M5995(GNLSA).

Existing amount: _____ New amount: _____ (can be purchased in units of $10,000)

Total Amount: _____ (maximum of $300,000)

☐ I wish to cancel Optional Spousal Life coverage

Optional AD&D (Policy No. 168002)

☐ I wish to apply for Optional AD&D coverage (no medical evidence required).

☐ Employee Total Amount: _____ (can be purchased in units of $10,000 to a maximum of $300,000) - must equal existing amount plus new amount elected

☐ Family

☐ I wish to cancel Optional AD&D coverage

Optional Critical Illness (Policy No. 168002)

☐ I wish to apply for coverage and have completed the M5995 (GNLSA):

☐ Employee $25,000 ☐ Spouse $10,000 ☐ Child $5,000 (no medical evidence required for children under the age of 16)

☐ I wish to cancel Optional Critical Illness coverage

Optional LTD (Policy No. 168001)

***Long Term Disability coverage is available to employees who are under the age of 65 and participate in the Public Service Pension Plan, Uniformed Services Pension Plan or the Members of the House of Assembly Plan**.

☐ I wish to apply for Optional LTD coverage and have completed the M5995(GNLSA). Please notify your Plan Administrator of any buyback or transfer of pensionable service as this may impact your premiums.

☐ I wish to cancel Optional LTD coverage

Optional Dental (Policy No. 168000)

☐ I wish to add/change Optional Dental coverage ☐ Single ☐ Family If applying for Dental benefits after 31 days from eligible date of employment coverage will be limited to $100 in the first 12 months.

☐ I wish to cancel Optional Dental coverage

5. Plan member name change

From: _____ (last name / first name / middle initial) To: _____ (last name / first name / middle initial)

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6. Plan member address change

From: _____
Street Address

_____
City | Province | Postal Code

To: _____
Street Address

_____
City | Province | Postal Code

7. Privacy

This section explains Canada Life's commitment to privacy.

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada 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 Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

8. Authorizations and declarations

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

I hereby apply for coverage under the group benefits plan issued by Canada Life.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

- my plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable;
- Canada 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;
- Canada 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 Canada 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 Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

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

If you require assistance completing this form please contact your Plan Administrator prior to submission. You are responsible for the accuracy and completeness of this form.

Plan administrator signature: _____ **Date:** _____

Clear