

To be completed by the plan administrator

Plan number: _____ Plan member name: _____

5. Beneficiary Designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

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

Please print clearly, in INK.

Beneficiary Designation

Beneficiary's Name(s)

Percent allocated

Relationship to plan member

last name

first name

middle initial

last name

first name

middle initial

last name

first name

middle initial

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below.

You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable", below.

I hereby make the above beneficiary designation: Revocable Irrevocable

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

6. Privacy

This section explains Great-West's commitment to privacy.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (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 benefits plan.

7. Authorizations and Declarations

This section must be signed by the plan member.

Authorizations and Declarations

I hereby apply for coverage under the group benefits plan issued by Great-West.

I authorize:

- My plan sponsor to deduct from my pay and remit to Great-West the plan member contribution required under the group benefits plan, if applicable;
- Great-West to use my social insurance number to administer my coverage and benefits under the group benefits plan, when required;
- Great-West, any healthcare provider, my plan administrator, other insurance companies, or benefit providers working with Great-West to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefits 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 this 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: _____