CANADA POST POSTES CANADA

DEPENDENT INFORMATION

THE Great-West Life ASSURANCE COMPANY

You must complete a Dependent Information form each time there is a change in your family status i.e. marriage, divorce, birth of your child, coordination of benefit changes and student status. If Great-West Life does not receive your form, your dependent claims will not be processed.

PLEASE INDICATE THE APPLICABLE PLAN NUMBER(S):

- ☐ **51391 (Extended Health Care Plan)**
- ☐ **51392 (Vision and Hearing Care Plan)**
- ☐ **162954 (Extended Health Care Plan for Retired Management & Exempt and Executives)**
- ☐ **51390 (Extended Health Care Plan for Executives)**
- ☐ **51057 (Dental Care Plan)**

EMPLOYEE STATUS:

- ☐ **Active**
- ☐ **Retired**

EMPLOYEE INFORMATION

Last Name	First Name	Employee ID Number	Date of Birth (Year Month Day)

Home Address: _____
Street

_____ Home Tel. (_____) _____
City Province Postal Code Area Code

Gender: ☐ Male ☐ Female

DEPENDENT INFORMATION

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

Effective date of change: Year Month Day

Reason for change:

☐ Birth of child ☐ Divorce ☐ Other (please specify) _____

☐ Marriage ☐ Cohabitation Date of marriage/cohabitation: Year Month Day

SPOUSAL INFORMATION

Add	Change	Last Name	First Name	Date of Birth (Year Month Day)	Gender
☐	☐				☐ Male ☐ Female

Delete	Last Name	First Name	Effective Date (Year Month Day)
☐			

What group benefits coverage does your spouse have through his/her employer?

Extended Health Care	Dental Care	Vision and Hearing Care	Drugs
Single ☐ Family ☐ Waived ☐ None ☐	Single ☐ Family ☐ Waived ☐ None ☐	Single ☐ Family ☐ Waived ☐ None ☐	Single ☐ Family ☐ Waived ☐ None ☐

Name of Spouse's Insurance Carrier: _____ Spouse's Plan Number: _____ Spouse's ID Number: _____

DEPENDENT INFORMATION

Add	Change	Delete	Last Name	First Name	Gender		Date of Birth (Year Month Day)	Full-Time Student	Dependent with a Disability
					Male	Female			
☐	☐	☐			☐	☐		☐ Yes	☐ Yes
☐	☐	☐			☐	☐		☐ Yes	☐ Yes
☐	☐	☐			☐	☐		☐ Yes	☐ Yes
☐	☐	☐			☐	☐		☐ Yes	☐ Yes
☐	☐	☐			☐	☐		☐ Yes	☐ Yes

If you have a dependent with a disability please note that their disability will be reviewed following their 21st birthday.

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. We collect, use and disclose the personal information to determine your eligibility for coverage and to administer the plan, including 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.

AUTHORIZATIONS AND DECLARATIONS

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

Authorizations and Declarations

I hereby apply for coverage for my spouse and/or unmarried dependent children under the group benfits plan and I confirm that I am authorized to act on their behalf.

I authorize:

- 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 to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of this Authorization 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.

Employee signature: _____ Date: _____

INSTRUCTIONS

Active employees mail completed form to:
THE GREAT-WEST LIFE ASSURANCE COMPANY
Group Electronic Enrollment 4 South
PO Box 6000 Station Main
WINNIPEG MB R3C 3A5

Retired employees mail completed form to:
THE GREAT-WEST LIFE ASSURANCE COMPANY
Benefits Administration Services - D227
PO Box 6000 Station Main
WINNIPEG MB R3C 9Z9

Clear

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