THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE

For GWL Head Office Use Only
GWL Certificate Number:

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 7 are to be completed by the plan member.

1. Plan Sponsor Section

This section is to be completed by the plan administrator.

Plan number: 106790 Division number: 1 Benefit class: 2

Plan sponsor: Nishnawbe-Aski Legal Services Corporation.

Plan member ID: _____ Cost centre (if applicable): _____

Eligible date of employment: Month 12 Day 21 Year 2009

Occupation: Restorative Justice Worker. Earnings: $ 45,000 per X year ○ month ○ week ○ hour

Plan member province of residence: ON Plan member province of employment: ON

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

Plan member name (print): Morris (last name) Vernon (first name) M (middle initial)

Gender: X Male ○ Female Date of birth: Month 04 Day 15 Year 59

Plan member mailing address:

Street address: General Delivery, 497, Moosehorn Road

City: Sioux Lookout, Province: Ontario Postal code: P8T-1J6

Do you have a spouse (married, common-law or civil union spouse)? X Yes ○ No

Do you have dependant children, including full time students or disabled adults? X Yes ○ No

How many dependants in total, including spouse? 2

3. Refusal of Benefits

This section is to be completed by the plan member.

Cross outs and/or corrections in this section must be initialled.

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits 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

Spousal insurer's name: _____ Plan number: _____

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 may be required to provide proof of insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. 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 of this form will be required for a life claim.

Crossed out or corrected beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

Beneficiary's name(s)			Percent allocated	Relationship to plan member
Morris (last name)	Marion (first name)	F (middle initial)	100%	Wife
_____ (last name)	_____ (first name)	_____ (middle initial)	_____	_____
_____ (last name)	_____ (first name)	_____ (middle initial)	_____	_____

To be divided as follows: ○ As per the percentages indicated above, or ○ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec 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**, I may change this beneficiary designation at any time

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.

CONTINUE ON REVERSE SIDE

To be completed by the plan administrator

Plan number: _____ Plan member name: _____ Plan member ID: _____

5. Dependant Information

This section is to be completed by the plan member.
Complete this section if the plan includes health and/or dental coverage and you have not refused such coverage for your dependants in section 3.
If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Spouse Information

last name	first name	middle initial
Morris	Marion	F

Date of birth (month/day/year): 04/08/60

Gender: Male ○ Female ☒

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

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
○	○	○	☒	○	○	○	☒	○	○	○	☒

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Dependant Information

last name	first name	middle initial	Date of birth month/day/year	Gender: Male	Gender: Female	Full time student: Yes	Disabled dependant: Yes
Morris	Marion	F	04/08/60	○	☒	○	○
Morris	Nigel	J	07/07/96	☒	○	☒	○
				○	○	○	○
				○	○	○	○

6. Privacy

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

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. 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. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

7. Authorizations and Declarations

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

Authorizations and Declarations

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

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 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;
- 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.

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 Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: Vernon Morris **Date:** December 01/09