Great-West Life APPLICATION FOR GROUP COVERAGE. For GWL Head Office Use Only

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 | Plan number: 106 790 Division number: 106 790 |
|--|---|
| This section is to be completed by the check the completed by | Plan sponsor: Nichnaube-Aski Legal Services Corporation. |
| a companiantinisator | <u> </u> |
| | Plan member ID: Cost centre (if applicable): rule 1D |
| | Eligible date of employment: Month 12 Day 21 Year 2009 = |
| | Occupation: Tustice Works Earnings: \$ 45,000 per year O month O week O hour |
| | Plan member province of residence: ON Plan member province of employment: ON |
| 2. Plan Member | Plan member name (print): Morris Vernon M Instrume Morris Instrume Middle Initial |
| Information | Gender: Male O Female Date of birth: Month 04 Day 15 Year 59 |
| This section is to be completed by the plan member. | Plan member mailing address: |
| Please print clearly, in INK | Street address: Geneval Delivery, 497, Mosehorn Road |
| | City: Stoux Lookout, Province: Ontario Postal code: P87-176 |
| | Do you have a spouse (married, common-law or civil union spouse)? |
| | Do you have dependant children, including full time students or disabled adults? X Yes O No |
| | How many dependants in total, including spouse? |
| 3. Refusal of Benefits | 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. |
| This section is to be completed by | I understand the plan of group benefits offered to me, but I decline to participate in: |
| the plan member. | Healthcare for O myself and my dependants O my dependants only |
| Cross outs and/or corrections in | Dentalcare for O myself and my dependants O my dependants only |
| this section must be initialled. | 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. |
| | Beneficiary Designation Percent Relationship |
| 4. Beneficiary | Beneficiary's name(s) allocated to plan member |
| Designation | Morris Mariou F 100% Wite |
| This section is to be completed by *the plan member: | |
| This section must be completed to designate a beneficiary for your | last name first name middle initial |
| life benefits, if applicable | last name first name middle initial |
| The original of this form will be required for a life claim. | To be divided as follows: As per the percentages indicated above, or |
| Crossed out or corrected | O 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 |
| beneticiary designations must be initialed. | banaficiary decignation irrevocable (meaning you may not change the designation of make certain changes to your |
| Please print clearly in INK | coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL. Note: Where Quebec law applies and your have designated your married spouse or civil union spouse as |
| | beneficiary, the designation will be irrevocable unless your check the circle marked revocable, perow. |
| | I hereby make the above beneficiary designation: Revocable, I may change this beneficiary designation at any time |
| Age of the second of the secon | If designating a heneficiery who is a minor or who lacks legal capacity you may wish to appoint a |
| | trustee/administrator by completing form #M6242 BlL. 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 |
| Pagging of the factor of | any proposed trustee/administrator. |

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Page 1 of 2

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| | 5: Dependant Information | | | Territoria en la composición de la composición del composición de la composición de la composición del composición de la composición del composición de la composición del composición del composición de la composición de la composición del composición del composición de la composición del composición | And the second second |
| | This section is to be completed by | the plan member. | by JA compared Charles . Parcial L. Bore | | |
| | Complete this section if the plan | n includes health and/or dental coverage ndants, please attach a separate list? P | e and you have not refused such co | overage for your dependants in section 3 | in anstrum |
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| | Spouse Information | , | What group benefits covera | ್ಯಾಂಪ್ರಿಕ್ಟ್ನ್ (ಸಂಗಾನಕೀರ) ige does your spouse have through h | is/her • |
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| i ī. | last name | first name middle init | HEALTHCARE III | DENTALCARE VISIONCARI | |
| ء <u>ر'</u> | Date of birth (month/day/year) | Gender | | 0 0 0 0 | X |
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| | Dependant Information | | | i. Full time Disab | oled |
| | | | Date of birth | Gender student depen | |
| Britis, "er, is | AA _ 1 | | *** - *** month/day/year *** ** | Male Female*** Yes ** Yes | s * |
| | INDCT15 | first name middle init | . <u>0.7/08/60</u> | - 0 × Ø 0 - c |), |
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| | | Protecting Your Personal Infor | | | · r |
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Plan member signature:

Date: <u>Necember 01/09</u>