## **Manulife**

## Group Benefits Enrolment or Re-enrolment Application

Please print clearly in dark ink using CAPITAL LETTERS.

Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member.

1	Plan sponsor statement	Plan sponsor name Ni3hmwbe ASKi ega Services Plan contract number_						
		Billing division Account/Division number Plan member's certificate number						
		Do you want the waiting period added to the hire date? Oyes ONo Permanent hire date (dd/mmm/yyyy) 04/JAU/ K						
		Re-hire date (dd/mmm/yyyy)  Community Legal  Class  Hours worked/week 35 Salary \$ 42,464 Frequency						
l d	certify that the plan r normal work schedule	nember listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works e of at least the set minimum hours par week as stated in the plan contract over a 52 week period including paid vacation.						
		Plan administrator signature Date (dd/mmm/yyyy) 07/07/00						
		Is evidence of insurability required? Yes SNo (in order to determine if evidence of insurability is required, please refer to your contract.)  If yes, please complete form GL0004E and send to Manulife for processing.						
2	Plan member information Plan member's last name W051eu First name Roberta							
	To be completed by	Date of birth (dd/mmm/yyyy) 411469 Gender OMale Female Province of residence						
	employee	Language English O French Do you have a spouse? (married, common law or civil union?) O Yes O No						
3 Plan member address (number, street, apt.) 19 Nabakhabo St BOX 26								
_		city On Sance Lake Province ON Postal code POLIBO						
4	For Quebec res	sidents (age 65 or over)  Are you participating in the RAMQ drug plan?   Yes   No						
5	Application for Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.							
		I am applying for Extended Health Care for I am applying for Extended Dental Care for						
	,	○ Myself only						
		Myself and 1 dependant (child or spouse)  Myself and 1 dependant (child or spouse)						
		Myself and 2 or more dependants (spouse and children)  Myself and 2 or more dependants (spouse and children)						
		None, because my spouse has coverage  None, because my spouse has coverage						
		Are you applying for Dependant Life?   Yes   No Dependant Life may be mandatory. Refer to the policy details.						
6	Coordination of benefits  This section is required if you are applying for coverage on your dependants.  Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan?  Yes  No							
		If yes, please provide the following details:  Name of other insurer						
ns	ured's last name	First name Date of birth (dd/mmm/yyyy)						
Effe	ective date of coverag	ldentification/certificate number Policy number						
Ple	ase indicate type of c	overage under other plan:  Extended Health Benefits  Dental Care  Single						
	cases where the infor fault value will be app	mation is not complete a Couple						

7 Dependant information	Complete the follow								
	in Section 5 Applica	ving section if the	e plan includes healti je.	h and/or dental cove	rage and yo	ı have not re	fused ben	efits for you	r dependants
Spouse	Last name First name Date of birth (dd/mmm/yyyy)								
If there is not enough room to list your	Gender () Male () Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy)								
dependants, attach details on a separate	**To apply for over-	**To apply for over-age disabled dependant coverage, please complete form GL0514E.							
sheet. Last name	First name			Date of birth (dd/mmm/yyyy)		Ge Male	Gender Male Female		Over-age disabled
Mandow	oga n	Deid	10	24/11	96	_ 0		0	dependant**
Wesley	J	Tan	inst	15/07	106	. 0	0	0	0
		NO. 1999		1 0		_ 0	0	0	0
8						0	0	0	0
8 Direct deposit	Transit number			<del>Awards y V</del>					
Complete the following section if you would	Institution number			MEMO	(armet or	00011#0	011114		
like to sign up for direct deposit of your claim	Bank account num	ber		Transit numb		tion number		number	
payments.  Electronic claim			ou will receive an invi	itation to register for	an online me	ember accou	nt.		
statement	Work email addres	s rwest	eyenanlegu	Personal e	mail address	roberto	i eves	sleyop	otmost ic
9 Authorization	and consent								
l authorize Manulife to	collect use maintai	hereunder may	be denied or terminal					piologding la	ge or any
or organization with Info plan administrator, insu- each other and with Ma on their behalf as if they deductions from my pay and administration, if m	ormation, including a rer, investigative age inulife, its reinsurers y were signing it ther y for my Group Bene y SIN is used as my	stigation, claim ny medical and ency, and any ad and/or its service nselves, and to fits plan, if appli- plan member ce	nersonal information remanagement, underwhealth professionals, iministrators of other leeproviders, for the Pedisclose and receive to cable. Lauthorize the ertificate number. Lag	ted as a result of the elevant to this applic viriting and for deterr facilities or provider benefits programs to urposes. Lam author their Information, for use of my Social Iruee a photocopy or	cation ("Information of the collect, use orized by my the Purpose surance Nurelectronic ve	mation") for the ligibility ("Pural regulatory and regulatory for this and regulatory and regulatory for this and regulatory for thi	plete, or more purpose, poses"). Labodies, and exchange to conser the purpose muthorizations.	nisleading in es of Group authorize any employer ge this informat to this Aut sponsor to poses of ide on is valid.	normation. Benefits any person r, group mation with thorization, make entification
or organization with Info plan administrator, insu- each other and with Ma on their behalf as if they deductions from my pay	ormation, including a rer, investigative age nulife, its reinsurers y were signing it ther y for my Group Bene y SIN is used as my Manulife to deposit I have identified on clal institution I chooke that upon the deportand and agree personal written end nt, to which I am not	stigation, claim ny medical and inney, and any ad and/or its service nselves, and to offits plan, if applipan member cet all payments ("this form. Lconse to name in the obsit of any Payments of any Payment relating entitled, either I	nersonal information remanagement, underwhealth professionals, iministrators of other leeproviders, for the Pedisclose and receive to cable. Lauthorize the ertificate number. Lag (Payments") due to mism that this direct be future; and shall rement(s) into the Accourage, at any time and with the payments.	ted as a result of the elevant to this applic viriting and for determined the properties of provider benefits programs to urposes. I am author their Information, for uree a photocopy or the from the above reank deposit authorized in valid until revolutional valid until revolution or the from the recomment of the until revolution or the from the deposit authorized in the until revolution or the deposit authorized in the until revolution of the until revolution or the deposit authorized in the until revolution of the until	cation ("informining plan ess, profession o collect, use orized by my the Purpose surance Nurelectronic veferenced Groation applies ked in writing lischarged froscontinue the knowledge	mation") for the ligibility ("Pui iligibility ("Pui iligibility ("Pui iligibility ("Pui iligibility ("Pui iligibility ("SIN")) for the same and the	plete, or m e purpose rposes"). I bodies, and d exchang to conser em my plan for the pur euthorizati policy ("Po cial Institut y duly aut er liability v sit of Payr eat any Pay	nisleading in easy of Group authorize a ny employer ge this information to this Authorize a sponsor to poses of ide on is valid. Olicy"), into the ion herein in horized represent the respect ment(s), as in yyment(s) ment(s) as in the second of the second	Benefits Benefits any person f, group mation with thorization, make entification the bank thamed by resentative to such requested add by
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or organization with Infoplan administrator, Insue each other and with Mu aon their behalf as if they deductions from my pay and administration, if m If applicable, Lauthoriz account ("Account") tha me and any other finant understand and agree Payment(s). Lalso und herein, and require my Manulife into the Accou Manulife, either by me of applicable, Lauthoriz understand such correcommunication. Lagree Manulife or by me pursuaddress maintained by Customer Service Cent Lunderstand that any I disability file. Access to Manulife emplements authorized the persons to when persons authorized.	ormation, including a rer, investigative age unulife, its reinsurers were signing it there of for my Group Bene by SIN is used as my a Manulife to deposite the age of the upon the dependent of the work of the upon the dependent, to which I am not or by representatives a manulife is not upon the dependent of the upon the dependent of the upon t	stigation, claim ny medical and more, and any ad and/or its service neelves, and to fits plan, if applipan member cet all payments ("this form. Loon set form Payments of any Payment Manulife meorsement relating entitled, either the of my estate. Doord with me the tain Information. Lagree should that if I do not to or collected the limited to: es, reinsurers, access; and	personal information in management, underwhealth professionals, iministrators of other lee providers, for the Pidisclose and receive to cable. Lauthorize the proficate number. Lag (Payments") due to mifirm that this direct be future; and shall relent(s) into the Accouracy, at any time and wing to future Payment(by contract or by law, or ough the email addression which I may incurre ould the email addression with the mail addression with the mail addression with the mail addression which I may incurred the mail addression with the email addression with the em	ted as a result of the elevant to this applic viriting and for determined the result of the programs to the result of the result	ration ("informining plan ess, profession o collect, use orized by my the Purpose surance Nur electronic versioned for action applies ked in writing discharged from regard a manner the eption by a tiporm change can remove rization, will!	mation") for the ligibility ("Pui iligibility ("Pui iligibility ("Pui maintain and pependants is. I authorize the fire of the finance of the	plete, or me purpose proses"). I bodies, and exchange to conser en my plan for the purpose gradient policy ("Pocial institute y duly authorization policy ("Pocial institute policy ("Pocial institute y duly authorization policy ("Pocial institute y duly authorization policy ("Pocial institute y duly authorization policy and any Payore immedia and en medite pronsible for the ponsible for the pons	nisleading in eas of Group authorize any employer ge this information to this Autoposes of ideon is valid. Slicy"), into the ion herein in horized represent the property of the property of the Purposes a secured in ansmission or updating the or by conferts life, here	Benefits any person (, group mation with thorization, make entification the bank the
or organization with Infoplan administrator, insue each other and with Ma on their behalf as if they deductions from my pay and administration, if m If applicable, Lauthoriz account ("Account") tha me and any other finance Lunderstand and agree Payment(s). Lalso und herein, and require my Manulife into the Account Manulife, either by me of the Information of the Manulife or by me pursuaddress maintained by Customer Service Cent Lunderstand that any disability file. Access to Manulife empleopersons to whe	ormation, including a rer, investigative age nulife, its reinsurers were signing it there y for my Group Bene y SIN is used as my a Manulife to deposite I have identified on cial institution I choose that upon the depersand and agree personal written end nt, to which I am not or by representatives a Manulife to correspondence may contain the total manulife. I understate. Information provided my Information provided my Information will loyees, representative on I have granted a wrized by law.	stigation, claim ny medical and more, and any ad and/or its service inselves, and to fits plan, if applipan member cet all payments ("this form. I consist of any Payments of any Payment and the set of any estate. Door with me the condition of my estate. Door with me the condition of any estate of the condition of any estate. Door with me the condition of any estate of the condition of the c	personal information in management, underwishealth professionals, iministrators of other lee providers, for the Pidisclose and receive to cable. Lauthorize the professionals, iministrators of other lee providers, for the Pidisclose and receive to cable. Lauthorize the profile that this direct be refiture; and shall reflect this direct be future; and shall reflect the future; and shall reflect the profile that the profile that the Information of the email addression with the email a	ted as a result of the elevant to this applic viriting and for determined their programs to the process. Lam authorities of my Social Interes a photocopy or efrom the above reank deposit authorizemain valid until revolution, thout prior notice, displayed thout prior notice, displayed the process identified on this stion is being sent in as a result of interest in the performance of the proportion of the performance of the proportion.	ration ("informining plan ess, profession o collect, use orized by my the Purpose surance Nur electronic versioned Gration applies ked in writing discharged from regard a manner the eption by a tiporm change can remove rization, will!	mation") for the ligibility ("Pui iligibility ("Pui iligibility ("Pui maintain and regulatory, maintain and Dependents is. I authorize the finance of this are to the finance, by me, or more any further address the direct depoins and agree they, and shall be the finance of the finance at is not guarantid party of a shall be the finance of the finance of the finance at its not guarantid party of a shall be the finance of the	plete, or me purpose proses"). I bodies, and exchange to conserve me policy ("Pocial institute y duly authorization come immedia and policy for the purpose immedia and purpose	nsteading in easy of Group authorize any employer gethis informate to this Authorize any employer gethis informate to this Authorized reproved in the control of the contro	Benefits any person and any person any pe
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Plan Member Administration Manulife Financial PO BOX 11006, STN CENTRE-VILLE MONTREAL QC H3C 4T8

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## Great-West Life APPLICATION FOR GROUP COVERAGE

ASSURANCE G COMPANY

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.

For GWL Head Office Use Only								
\$	GWL Certificate Number							
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Plan sponsor Section This section is to be completed by the plan administration.  Plan sponsor INTHANGE ASE   CGAL SCAUCES   Colf   Plan sponsor INTHANGE ASE   CGAL SCAUCES   Plan								
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Date of full time employment: Month		Plan sponsor: NISHNAWISE-ASKI LEGAL SERVICES CORP.						
Occupation: The Land Park Earnings: \$ 38.00 per Xyear   month   week   hour   Plan member province of residence:								
Plan member province of residence:	· · · · · · · · · · · · · · · · · · ·	Date of full time employment: World Day Teal						
Plan member name (print): Wesley Roberts for name information This section is to be completed by the plan member. Please print clearly, in INK.  Please print clearly, in INK.  Please print clearly, in INK.  Residence of the plan member name (print): Wesley Roberts (prin		Occupation: FACULTATION   Earnings: \$ 38,000 per year   month   week   hour						
Information This section is to be completed by the plan member. Please print clearly, in INK.    Please print clearly, in INK.   Please print clearly, in INK.		Plan member province of residence: ONT Plan member province of employment: ONT.						
This section is to be completed by the plan member.  Please print clearly, in INK.    Please print clearly, in INK.   Province:   Province	2. Plan Member	11 11 11 11 11 11 11 11 11 11 11 11 11						
Please print clearly, in INK.  Please print clearly, in INK.  Street address:  Street address:  Street address:  Street address:  Street address:  Street address:  Do you have a spouse (married, common-law or civil union spouse)?  Do you have dependant children, including full time students or disabled adults?  How many dependants in total, including spouse?  And the member.  Cross outs and/or comedions in this section is to be completed by the plan member.  Cross outs and/or comedions in this section must be initialed.  Dentalcare for   myself and my dependants   my dependants and post of the participate in: I understand the plan of group benefits differed to me, but I decline to participate in: I understand the plan of group benefits differed to me, but I decline to participate in: I understand the plan of group benefits differed to me, but I decline to participate in: I understand the plan of group benefits differed to me, but I decline to participate in: I understand the plan of group benefits differed to me, but I decline to participate in: I understand the plan of group benefits differed to me, but I decline to participate in: I healthcare for   myself and my dependants   my dependants only Department on the participate in: I healthcare for   myself and my dependants only Department on the participate in: I healthcare for   myself and my dependants may be required to provide proof of I insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be initiated.  Please see your plan administrator for details.  Beneficiary  Designation  This section is to be completed to designate a beneficiary for your life benefits, if applicable.  The original of this form will be required to designate a beneficiary of your member.  This section is to be completed to designate a beneficiary of seignation.  Percent aduction to the original propose.  The part of the participate in		test metre						
City: Castuck   Province: DD   Postal code: POLIBO   Do you have a spouse (married, common-law or civil union spouse)?   Yes   No   Postal code: Political   Political   Postal code: Political   Po	•							
Do you have a spouse (married, common-law or civil union spouse)?  Do you have dependant children, including full time students or disabled adults?  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.  Indestand 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   Dentalcare for   myself and my dependants   my dependants only   Dentalcare for   myself and my dependants   my dependants only   Spousal insurer's name:   My ou lose spousal coverage you must apply for coverage within 3f days of loss of such coverage. If you do not apply within 3f 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 This section must be completed by the plan member.  It is benefits, if applicable.  The original of this form will be required for a like claim.  Crossed out or corrected beneficiary for size dain.  Please print clearly, in INK.  Note: Where Quebec law applies and you have designation or make certain changes to your coverage under the plan without the written consent of the beneficiary please complete form #M6248 BIL.  Note: Where Quebec law applies and you have designation or any wish to appoint a trustee/ administrator, by completing form #M6242 BIL. This application and with the precomment you consult with a legal advisor, and with	Please print clearly, in INK.	Chor available in						
Do you have dependant children, including full time students or disabled adults?  How many dependants in total, including spouse?  A Refusal of Benefits  This section is to be completed by the plan member.  Cross outs and/or corrections in this section must be initialed.  Penaltoare for myself and my dependants   my dependants only   Spousal insurer's name:   myself and my dependants may be required for post initialed.  Please see your plan administrator for details.  Beneficiary  Designation  This section must be completed by the plan member.  This section is to be completed by dependants only   my dependants								
3. Refusal of Benefits This section is to be completed by the plan member.  Cross outs and/or corrections in this section must be initiated.  Please print clearly, in INK.  Please print clearly, in INK.  How many dependants in total, including spouse?  How many dependants in total, including spouse?  Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate 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 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  This section is to 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 initiated.  Please print clearly, in INK.  Please print clearly, in INK.  Please print clearly, in INK.  Note: Where Quebec law applies and you have designated above, or coverage under the plan without the written consent of the beneficiary) please complete form #M6348 Bill.  Note: Where Quebec law applies and you have designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 Bill.  Note: Where Quebec law applies and you have designation at any time upon notice to Great-West Life. If you wish to make the beneficiary the designation of the beneficiary please complete form #M6348 Bill.  Note: Where Quebec law applies and you have designation or marke certain changes to your coverage under the plan without the written consent of the beneficiary) please		Do you have a spouse (married, common law or own limits openes).						
3. Refusal of Benefits This section is to be completed by the plan member.  Cross outs and/or corrections in this section must be initiated.  Please print clearly, in INK.  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   Spousal insurer's name:   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 of understand the plan of unitary 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 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 initiated.  Please print clearly, in INK.  Please print clearly, in INK.  Please print clearly, in INK.  Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate in:  Healthcare for   myself and my dependants   my dependants only   my dependants   my dependants only   my dependants only   my dependants only		/ 4						
Spousal insurer's name:	This section is to be completed by the plan member.  Gross outs and/or corrections  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							
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  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.  Please print clearly, in INK.  Note: Where Quebec law applies and you have designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation will be 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 designation at any time upon notice to Great-West Life. If you wish to make the beneficiary, the designation will be 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 designation at any time upon notice to Great-West Life. If you wish to make the beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable", below.  I hereby make the above beneficiary designation at any time upon notice to Great-West Life. If you wish to make 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 check the circle marked "Revocable", below.  I hereby make the above	HI HIS SCOOL HIMSE SO SIMANOS.							
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.  Please print clearly, in INK.  Beneficiary's name(s)  Mendowegan  Darwy  This section must be completed to designate a beneficiary of pour life to this form will be required for a life claim.  Crossed out or corrected beneficiary designations must be initialed.  Please print clearly, in INK.  Please print clearly, in INK.  Please print clearly, in INK.  Please print clearly in INK.  Please print		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.						
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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.  Please print clearly, in INK.  Issued to the plan will be required for a life claim.  Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable. I may change this beneficiary designation:    Revocable, I may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary out 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	ν,	Beneficiary's name(s)  Mendowka an Darwin CP 30% 01/13/91 50 h						
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.  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	• • • •	last name O first name middle initial						
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.  Please print clearly, in INK.  To be divided as follows:  X 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		lest name ( first name middle initial						
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		If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with						

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To be completed by the plan administrator  Plan member in:  Plan member in:									
Plan number: 106790	_ Plan member	name: \text{\chi}C	SOPVIA WESTER	/ 위	au mëmp	er in:	*		
5. Dependant Information		المري	na regardent general meneral da . El a	on alleganists		,	•		
This contion is to be completed by t	he 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	Spouse information  What group benefits coverage does your spouse have through his/her employer?								
	<u></u> .	<del> </del>	HEALTHCARE	DENTALO Single Family Wa			ONCARE ity Waived None		
last name  Date of birth (month/day/year)	first name	middle initial Gender	Single Family Waived None	Oligie ('Sum' And					
Date of Diffit (month/day/year)		Male Female	Where applicable, benefit pay spouse's plan.	ments will be co	ordinated	between this	s plan and your		
Dependant Information	-		<u> </u>			Full time	Disabled		
	Sue .		Date of birth month/day/year	Gen Male	der Female	student Yes	dependant Yes		
Mendowegan	Dunin	$\rho \rho$	01/13/91						
last name	first name	middle initial	11/4//2		•	<i>P.</i> -	•		
Mendowegan	De 101/12 first name	/\//) middle initial	11/24/96						
We, Sley	Tannes	TP	02/15/06						
last name	first name	middle initial AT	04/19/95						
last name	first name	middle initial							
This section explains Great-West Life's commitment to privacy.  When you apply for coverage, we establish a confidential file that contains your personal information in your personal information in your may exercise certain rights of access and rectification with respect to the personal information in your by sending a request in writing to Great-West Life. Great-West Life may use service providers located with 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, at persons authorized by law. Your personal information may be subject to disclosure to those authorized upplicable law within or outside Canada. We collect, use and disclose the personal information to determine eligibility for coverage, and to administer the plan, including investigating and assessing claims, and creating maintaining records concerning our relationship.							reat-West Life. ion in your file cated within or ons authorized access, and to thorized under determine your		
7. Authorizations and	Authorizations	s and Declaration	s						
Declarations	I hereby apply	for coverage unde	r the group benefits plan iss	ued by Great-V	Vest Life.				
This section must be signed and dated in INK by the plan member.  I authorize:  my plan sponsor to deduct from my pay and remit to Great-West Life the plan member required under the plan, if applicable;					r contributions				
	<ul> <li>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;</li> </ul>								
	<ul> <li>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.</li> </ul>								
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 <u>Authorizations and Declarations</u> section is as valid original.						is vand as the			
	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 A Model Date: Jan 4/10								