THE Great-West Life ASSURANCE COMPANY

GROUP COVERAGE CHANGE FORM

For GWL Head Office Use Only

GWL Certificate Number

Please print clearly and complete this form, in INK. Sections 1 is to be completed by the plan administrator and sections 2 through 7 are to be completed by the plan member, for applicable changes. The plan administrator should attach this form to the plan member's application.

1. General Enrollment Information

Policy number: 335330 Certificate Number: _____

Plan sponsor: DOCTORS MANITOBA

Plan member name: _____
last name first name middle initial

2a. Beneficiary Designation Change*

This section must be completed to change the designated beneficiary or beneficiaries for your life benefits.

Crossed out beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Beneficiary's name(s)	Percent allocated	Relationship to plan member
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).

Contingent beneficiary - If the above beneficiary dies before me, the death benefit set out in the plan is to be paid to:

☐ My estate, or

Name of contingent beneficiary Relationship to Plan Member

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

2b. Spousal Beneficiary Designation Change*

This section must be completed to change the designated beneficiary or beneficiaries for your life benefits.

Crossed out beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Beneficiary's name(s)	Percent allocated	Relationship to plan member
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)

Contingent beneficiary - If the above beneficiary dies before me, the death benefit set out in the plan is to be paid to:

☐ My estate, or

Name of contingent beneficiary Spouse

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

*You may change this beneficiary designation at any time upon notice to Great-West Life.

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee / administrator by completing the Trustee Appointment section of this form. This appointment may not be suitable for all purposes.

3. Current Beneficiary Name Change

Complete if a current beneficiary has had a legal change of name.

From: _____ To: _____
last name first name middle initial last name first name middle initial

Relationship to plan member: _____

4. Plan Member Name Change

From: _____ To: _____
last name first name middle initial last name first name middle initial

5. Trustee Appointment

You may wish to appoint a trustee/administrator by completing this section.

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

Please print clearly, in INK.

Do not complete this section if you are a Quebec Resident.

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing this form. 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.

Do not complete this section if you have made another trustee/administrator appointment.

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release The Great-West Life Assurance Company from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in trust.

_____ _____
Trustee last name first name middle initial Relationship to plan member

6. 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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes 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.

7. Authorizations and Declarations

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

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

I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information".

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 or the above to exchange personal information, when relevant and 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 the 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: _____ **Date:** _____

Plan administrator signature: _____ Date: _____

"Doctors Manitoba" is a trade name of the Manitoba Medical Association

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