THE Great-West Life ASSURANCE COMPANY

PEBA Extended Health Care Plan Retiree Enrolment Form

Please complete and return this form to Great-West Life National Accounts Enrolment-D102 PO Box 6000 Winnipeg MB R3C 3A5.

1. Retiree Information

First Name	Last Name	Sex	Date of Birth (DD/MM/YYYY)
		☐ M ☐ F	

Address	City	Province	Postal Code

Phone	Provincial Health Care Coverage in Place?
	☐ Yes ☐ No

Group from which you retired	Member ID	Date of Retirement (DD/MM/YYYY)
☐ PS/GE SGEU (168851) ☐ CUPE 600-3 (168852) ☐ Out-Of-Scope (168854)		

2. Coverage Information

Extended Health Care coverage under this plan is for:	Coverage Effective Date (DD/MM/YYYY)
☐ Single ☐ 1 dependent ☐ 2 or more dependents	

3. Dependent Information

Complete this section if you have eligible dependents.

Spouse Information[1] **Date of birth** (DD/MM/YYYY) **Gender** Male ☐ Female ☐

last name first name middle initial

Dependant Information

last name	first name	middle initial	Date of Birth DD/MM/YYYY	Gender Male	Gender Female	Provincial Health Care Coverage in Place?	Dependent age 21 or over?[2] Yes	Disabled Dependent Yes
				☐	☐	☐ Yes ☐ No	☐	☐
				☐	☐	☐ Yes ☐ No	☐	☐
				☐	☐	☐ Yes ☐ No	☐	☐
				☐	☐	☐ Yes ☐ No	☐	☐

[1] If your spouse is common-law, please complete the following:

I have been living with and representing the above as my spouse since _____ (DD/MM/YYYY). My common-law spouse and I are financially responsible for all our dependents claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

[2] For each dependent age 21 and over:

- in the case of a student dependent under age 25, please indicate the educational institution where the child is receiving full-time training:

  _____

- in the case of a dependent due to a developmental or physical disability, please attach the PEBA Retiree Over-Age Dependent Questionnaire form M6943(PEBARR).

continued...

Are you, your spouse or dependent(s) covered by any other insurance plan?

☐ Yes (please complete the following) ☐ No (please skip to 4)

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

HEALTHCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None
☐	☐	☐	☐	☐	☐	☐	☐

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

4. Payment Options

☐ **Monthly Pre-Authorized Debit** *(Please attach the Pre-Authorized Debit Agreement ("PAD") form M6940(PEBA).*

5. 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.

6. Authorization and Declaration

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:

- Great-West Life to withdraw monthly from my account, the contributions required under 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 dependents, 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.

Signature: _____ **Date:** _____

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Great-West Life
National Accounts Enrolment-D102
PO Box 6000
Winnipeg MB R3C 3A5