



APPLICATION FOR NON-SMOKER RATE FOR OPTIONAL INSURANCE

Please print clearly and complete this form, in INK.

5. Authorizations and Declarations

This section must be signed and dated in INK by the insured (plan member or spouse).

I hereby apply for coverage under the group benefits plan issued by Canada Life.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

- my plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable;
- Canada 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;
- Canada 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 Canada 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: _____

Return to: Public Employees Group Life Insurance Plan
Public Employees Benefits Agency (PEBA)
1000 - 1801 Hamilton Street
Regina, SK S4P 4W3

Authorized PEBA Signature _____ Date (Month/Day/Year) _____

Authorized PEBA Signature _____ Date (Month/Day/Year) _____