APPLICATION FOR GROUP COVERAGE
EMPLOYEE BASIC LIFE INSURANCE, EMPLOYEE OPTIONAL LIFE INSURANCE, OPTIONAL DEPENDENT LIFE INSURANCE

For Canada Life Head Office Use Only
Canada Life Certificate Number

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 8 are to be completed by the employee. Return completed forms to: Shared Services 10230 Jasper Ave Edmonton T5J 0B2 or to Staff Service Centre.

1. Employer section

This section is to be completed by the plan administrator.

SUPPORT STAFF POLICY #: ☐ **335042** (Basic Life) ☐ **335043** (Optional Employee Life)
☐ **335042** (Optional Dependent Life)

CLASS: _____

Employer name: UNIVERSITY OF ALBERTA

Date of eligibility: Month _____ Day _____ Year _____

2. Employee Section

This section is to be completed by the employee.

Please print clearly in INK.

Employee name (print): _____
last name first name middle initial

Employee ID: _____

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other Date of birth: Month _____ Day _____ Year _____

Do you have a spouse? ☐ Yes ☐ No

Do you have dependant children, including full time students or disabled adults? ☐ Yes ☐ No

3. Employee Optional Life Insurance and Optional Dependent Life Insurance

This section is to be completed by the employee.

Optional Employee Life

☐ I wish to apply for _____ units (1-50) of employee optional life (each unit is equal to $10,000 of coverage).

Medical evidence is not required if applying within 90 days of date of eligibility for any amount listed up to and including $100,000 (10 units). If you wish to apply for amounts exceeding this, up to $500,000, please complete the Evidence of Insurability Coverage Detail form available from Pension & Benefit Advisory Services.

Within the past 12 months have you smoked or used cigarettes, marijuana, hashish, cigars, pipe cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts, or tobacco, or nicotine in any other form.

☐ Yes ☐ No

☐ I do not wish to apply for this benefit.

Optional Dependent Life

☐ I wish to apply for optional dependent life of $15,000 on my spouse and $5,000 on each child.

☐ I do not wish to apply for this benefit.

4. Beneficiary Appointment - Employee Basic Life and Employee Optional Life Insurance

The original or copy of this original form will be required for a Life claim.

Please print clearly, in INK.

I hereby appoint the beneficiary of my insurance to be paid in the event of my death. Where I have named more than one beneficiary, each is allocated an equal share of my insurance unless I have indicated otherwise.

Primary Beneficiary Employee Basic Life	Percent allocated	Relationship to plan member	Basic Life	Opt Life
_____ last name _____ first name _____ middle initial	_____	_____	☐	☐
_____ last name _____ first name _____ middle initial	_____	_____	☐	☐
_____ last name _____ first name _____ middle initial	_____	_____	☐	☐
_____ last name _____ first name _____ middle initial	_____	_____	☐	☐
_____ last name _____ first name _____ middle initial	_____	_____	☐	☐

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5. Contingent beneficiary designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Contingent Beneficiary			Percent allocated	Relationship to plan member		
last name	first name	middle initial			Basic Life ☐	Opt Life ☐
last name	first name	middle initial			Basic Life ☐	Opt Life ☐
last name	first name	middle initial			Basic Life ☐	Opt Life ☐

To be divided as follows: ☐ As per the percentage indicated above, or
☐ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Canada 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 box marked "Revocable", below.

I hereby make the above beneficiary designation:

☐ **Revocable, I may change this beneficiary designation at any time**

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Canada Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. **Before designating a trust, you should seek legal advice.**

For All Other Applicants - 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. **Before designating a trustee, you should seek legal advice.**

6. Trustee appointment

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

An original or copy 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 Canada 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

7. Privacy

This section explains Canada Life's commitment to privacy.

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada 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 Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

CONTINUED ON NEXT PAGE

8. Authorizations and declarations

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

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:** _____