GROUP COVERAGE CHANGE FORM

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.

Canada Life will accept the original or a copy of this form when the life claim is submitted.

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 deah 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.

Canada Life will accept the original or a copy of this form when the life claim is submitted.

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 Canada 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.

Canada Life will accept the original or a copy of this form when the life claim is submitted.

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

6. 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.

7. 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:** _____

Plan administrator signature: _____ **Date:** _____

“Doctors Manitoba” is a trade name of the Manitoba Medical Association

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