

CANADA LIFE INSURED BENEFITS FORM

(formerly Great-West Life)

 OPSEU Pension Trust 1 Adelaide Street East, Suite 1200, Toronto, Ontario M5C 3A7
 Telephone: 416-681-6100 Toll-free: 1-800-637-0024 Fax: 416-681-6175 www.optrust.com

Information is collected by OPTrust and coverage of benefits is provided through Canada Life.

PERSONAL INFORMATION

Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)	OPTrust ID Number
<input type="text"/>	<input type="text"/>	<input type="text" value="D D M M Y Y Y Y"/>	<input type="text"/>
E-mail Address	Home Telephone Number	Business Telephone Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Home Address: Number and Street			Apt. No.
<input type="text"/>			<input type="text"/>
City/Town	Province	Postal Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Marital Status:			
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Common-law	<input type="checkbox"/> Separated
<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed		

COVERAGE

Type of Coverage	Retirement Effective Date (DD/MM/YYYY)
<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="text" value="D D M M Y Y Y Y"/>

SPOUSAL INFORMATION

Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text" value="D D M M Y Y Y Y"/>

DEPENDANT INFORMATION

[1] Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text" value="D D M M Y Y Y Y"/>
<input type="checkbox"/> Dependant Under Age 21	<input type="checkbox"/> Full Time Student Age 21-25	<input type="checkbox"/> Disabled Age 21 or older
[2] Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text" value="D D M M Y Y Y Y"/>
<input type="checkbox"/> Dependant Under Age 21	<input type="checkbox"/> Full Time Student Age 21-25	<input type="checkbox"/> Disabled Age 21 or older

COORDINATION OF BENEFITS

 Does your spouse have group insurance coverage under any other plan? Yes No

If "Yes", indicate if you or any member of your family are entitled to benefits under any other plan:

Medical	Dental	Vision/Hearing
<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived
Name of Spouse's Insurance Carrier	Spouse's Plan Number	Spouse's ID Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

LIFE INSURANCE BENEFICIARY DESIGNATION

Life Insurance

Elected \$2,000 Waived \$2,000 **Please Note:** If you decide to waive the life insurance, you must sign the waiver to opt out.

Last Name	First Name and Initials	Relationship to You
<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail Address	Home Telephone Number	Business Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Address: Number and Street	Apt. No.	
<input type="text"/>	<input type="text"/>	
City/Town	Province	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

You may change this beneficiary designation at any time upon completion of a new form or written notification.

PRIVACY

OPTrust and Canada Life Assurance Company recognize the importance of privacy. The personal information collected on this form is used to process your insured benefit changes. When you apply for coverage, Canada Life sets up a confidential file that is kept in the office of Canada Life or the office of an organization authorized by Canada Life. The information is required by OPTrust and Canada Life to: ensure your eligibility for insured benefits and the payment of claims is correct, respond to your questions, and comply with audit purposes. Access to your file is limited to OPTrust staff or persons authorized by us; Canada Life staff or persons authorized by Canada Life who require it to perform their duties; to persons who you have granted access and to persons authorized by law.

AUTHORIZATION AND DECLARATION

I hereby apply for benefits under the Province of Ontario Pensioner's Group Insurance Plan indicated in this application.
I authorize:

- OPTrust to deduct from my pension and remit to the insurance provider the pensioner contribution required under the plan, if applicable;
- the use of my OPTrust ID where it is required to protect pensioner privacy and confidentiality in the administration of the plan;
- Canada Life, any health care provider, OPTrust, other insurance or re-insurance companies, administrators or government benefits or other benefit programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my surviving spouse and/or dependant, I certify my insurable interests and confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorization and Declaration section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Retiree's Signature

Date Signed (DAY/MM/YYYY)