DEPENDENT INFORMATION

You must complete a Dependent Information form each time there is a change in your family status i.e. marriage, divorce, birth of your child, coordination of benefit changes and student status. If Canada Life does not receive your form, your dependent claims will not be processed.

PLEASE INDICATE THE APPLICABLE PLAN NUMBER(S):

- ☐ **51391 (Extended Health Care Plan)**
- ☐ **51390 (Extended Health Care Plan for Executives)**
- ☐ **51392 (Vision and Hearing Care Plan)**
- ☐ **51057 (Dental Care Plan)**
- ☐ **162954 (Extended Health Care Plan for Retired Management & Exempt and Executives)**

EMPLOYEE STATUS:

- ☐ **Active**
- ☐ **Retired**

EMPLOYEE INFORMATION

Last Name	First Name	Employee ID Number	Date of Birth (Year / Month / Day)

Home Address: ______________________________
Street

______________________________ Home Tel. (_______) ______________
City Province Postal Code Area Code

Gender ☐ Male ☐ Undisclosed ☐ Female ☐ Other

DEPENDENT INFORMATION

This section must be completed if you are adding or deleting a dependent or updating dependent information. If there are more than four dependents, please attach a separate list. Please print clearly, in INK.

Effective date of change: Year | Month | Day

Reason for change:

☐ Birth of child ☐ Divorce ☐ Other (please specify) ______________

☐ Marriage ☐ Cohabitation Date of marriage/cohabitation: Year | Month | Day

SPOUSAL INFORMATION

Add	Change	Last Name	First Name	Date of Birth (Year / Month / Day)	Gender
☐	☐				☐ Male ☐ Undisclosed ☐ Female ☐ Other

Delete	Last Name	First Name	Effective Date (Year / Month / Day)
☐			

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

	Single	Family	Waived	None
Extended Health Care	☐	☐	☐	☐
Dental Care	☐	☐	☐	☐
Vision and Hearing Care	☐	☐	☐	☐
Drugs	☐	☐	☐	☐

Name of Spouse's Insurance Carrier: ______________ Spouse's Plan Number: ________ Spouse's ID Number: ________

DEPENDENT INFORMATION

Add	Change	Delete	Last Name	First Name	Gender	Date of Birth (Year / Month / Day)	Full-Time Student	Dependent with a Disability
☐	☐	☐			☐ Male ☐ Undisclosed ☐ Female ☐ Other		☐ Yes	☐ Yes
☐	☐	☐			☐ Male ☐ Undisclosed ☐ Female ☐ Other		☐ Yes	☐ Yes
☐	☐	☐			☐ Male ☐ Undisclosed ☐ Female ☐ Other		☐ Yes	☐ Yes
☐	☐	☐			☐ Male ☐ Undisclosed ☐ Female ☐ Other		☐ Yes	☐ Yes
☐	☐	☐			☐ Male ☐ Undisclosed ☐ Female ☐ Other		☐ Yes	☐ Yes

If you have a dependent with a disability please note that their disability will be reviewed following their 21st birthday.

PRIVACY

This section explains Canada Life's commitment to privacy.

Protecting Your Personal Information

At **The Canada 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 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. Canada Life may use service providers located within or outside Canada. 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, 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. We collect, use and disclose the personal information to determine your eligibility for coverage and to administer the plan, including 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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

AUTHORIZATIONS AND DECLARATIONS

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

Authorizations and Declarations

I hereby apply for coverage for my spouse and/or unmarried dependent children under the group benfits plan and I confirm that I am authorized to act on their behalf.

I authorize:

- 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 to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of this Authorization 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 Québec applicants: I request that this form be in English
Je demande que ce formulaire me soit remis en anglais.

Employee signature: ______________________________ Date: ______________

INSTRUCTIONS

Active employees mail completed form to:
THE CANADA LIFE ASSURANCE COMPANY
Group Electronic Enrollment 4 South
PO Box 6000 Station Main
WINNIPEG MB R3C 3A5
Fax: 204-946-4699
Email: CPCdepformGEE@canadalife.com

Retired employees mail completed form to:
THE CANADA LIFE ASSURANCE COMPANY
Benefits Administration Services - D227
PO Box 6000 Station Main
WINNIPEG MB R3C 9Z9
Fax: 204-946-7405
Email: BAS@canadalife.com

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Clear