



Enrolment Form

Les services à l'enfance Grandir ensemble
Group insurance benefits – Great West Life, Policy # 165729

To be completed by the Daycare Centre

| | | |
|---|---------------|---|
| Name of the Centre | | |
| Annual salary | Date of hire | Date of eligibility (3 months after date of hire) |
| <input type="checkbox"/> New participant <input type="checkbox"/> Reinstatement ID # _____ | Plan (A or B) | Comments |
| I declare that the information above is accurate and true. | | |
| Signature of the Direction _____ Date _____ | | |

Identification of the Participant – PRINT clearly, in INK

| | | | |
|-------------|----------------------------|---|--|
| Last name | | First name | |
| Address | | | Telephone (home) |
| City | Province | | Telephone (work) |
| Postal code | Date of birth (mm/dd/yyyy) | Language preference <input type="checkbox"/> English <input type="checkbox"/> French | Sex <input type="checkbox"/> F <input type="checkbox"/> M |

Coverage Requested

- Life insurance for dependants Yes (**mandatory** if you have a spouse, legal or common-law, and/or children)
 No
- Extended Health Care Single Family (**mandatory** for Québec residents, unless covered somewhere else)
 Dental Care Single Family
- I refuse the extended health care coverage because I am covered by my spouse's plan.
 I refuse the dental care coverage because I am covered by my spouse's plan.

Information on the Spouse and Dependants

Is your spouse covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan?

- Yes If yes, please indicate spouse's coverage and name of his/her insurer
 No

- Extended Health Care** Single Family
Dental Care Single Family
Vision Care Single Family

Name of insurer _____

| | | | |
|---------------------|------------------|--|----------------------------|
| Spouse's given name | Spouse's surname | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (mm/dd/yyyy) |
|---------------------|------------------|--|----------------------------|

| Child's given name | Child's surname | Sex | Date of birth (mm/dd/yyyy) | Disabled | ** Student (22-26 yrs) | For children 22 to 26 years old; name of educational institution |
|--------------------|-----------------|--|----------------------------|---|---|--|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

** **Student:** child aged between 22 and 26, who is a full-time student (15 hours/week) attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.

Beneficiary

| | | |
|------|---------------------------------|------------|
| Name | Relationship to the participant | Percentage |
| Name | Relationship to the participant | Percentage |
| Name | Relationship to the participant | Percentage |
| Name | Relationship to the participant | Percentage |

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

You may change this beneficiary designation at any time upon notice to Great-West 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 **Québec 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 at any time

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.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

Privacy**Protecting Your Personal Information**

At **The Great-West Life Assurance Company (Great-West)**, 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 Great-West Life or the offices of an organization authorized by Great-West 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 Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West 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 of Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Authorizations and Declarations

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

I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information"

I authorize:

- My plan sponsor to deduct from my pay and remit to Great West Life the plan member contributions required under the plan, if applicable;
- Great West 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;
- Great West 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 Great West 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 Québec applicants: I requested that this form be in English./J'ai demandé que ce formulaire me soit remis en anglais.

I have read the "Guidelines for employees" by Grandir ensemble and agree to respect and adhere to these guidelines.

| | |
|--------------------------|------|
| Signature of Participant | Date |
|--------------------------|------|