PLANNERA Extended Health Care and Dental Plan Retiree Enrollment Form

1. Retiree Information

First Name	Last Name	Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other	Date of Birth (DD/MM/YYYY)

Address	City	Province	Postal Code

Phone	Email	Provincial Health Care Coverage in Place? ☐ Yes ☐ No

Group from which you retired ☐ PS/GE SGEU (168851) ☐ CUPE 600-3 (168852) ☐ Out-Of-Scope (168854)	Member ID	Date of Retirement (DD/MM/YYYY)

2. Coverage Information - You must be enrolled in the Extended Health Care Plan to opt in to the Dental Plan

Coverage under this plan is for:

Extended Health Care Plan Dental Plan ☐ Yes ☐ No

☐ Single ☐ 1 dependent ☐ 2 or more dependents

Coverage Effective Date (DD/MM/YYYY)

3. Dependent Information

Complete this section if you have eligible dependents.

Spouse Information[1]

last name first name middle initial

Date of birth (DD/MM/YYYY)

Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Dependant Information

			Date of Birth DD/MM/YYYY	Gender	Provincial Health Care Coverage in Place?	Dependent age 21 or over?[2]	Disabled Dependent
last name	first name	middle initial		☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐ Yes ☐ No	☐	☐
last name	first name	middle initial		☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐ Yes ☐ No	☐	☐
last name	first name	middle initial		☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐ Yes ☐ No	☐	☐
last name	first name	middle initial		☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐ Yes ☐ No	☐	☐

[1] If your spouse is common-law, please complete the following:

I have been living with and representing the above as my spouse since _____ (DD/MM/YYYY). My common-law spouse and I are financially responsible for all our dependents claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

[2] For each dependent age 21 and over:

- in the case of a student dependent under age 25, please indicate the educational institution where the child is receiving full-time training:

  _____

- in the case of a dependent due to a developmental or physical disability, please attach the Plannera Retiree Over-Age Dependent Questionnaire form M6943(PEBARR).

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Are you, your spouse or dependent(s) covered by any other insurance plan?
☐ Yes (please complete the following) ☐ No (please skip to 4)

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

HEALTHCARE				VISIONCARE				DENTALCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

4. Payment

Monthly Pre-Authorized Debit *(Please attach the Pre-Authorized Debit Agreement ("PAD") form M6940.*

Please also provide of a "VOID" cheque or direct deposit form from your financial institution. We require this to ensure we set up your account correctly.

5. 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.

6. Authorization and Declaration

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:** _____

Benefits Administration Solutions - D227
60 Osborne Street N.
Winnipeg, MB R3C 1V3
Email• BAS@canadalife com
1-866-656.5119

Clear