



Great-West Life Insured Benefits Change Form Policy 157838

OPSEU Pension Trust

Fiducie du régime de
retraite du SEFPO

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Use this form to make changes to your insured benefits coverage and/or to provide specific details about your dependants. Information is collected by OPTrust and your insured benefits coverage is provided through the Great-West Life Assurance Company. **(Continued on reverse.)**

PERSONAL INFORMATION CHECK HERE IF THIS IS A NAME CHANGE:

Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)	OPTrust ID Number
<input type="text"/>	<input type="text"/>	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"/>	

DEPENDANT INFORMATION CHANGE

This section must be completed if you are adding, deleting, confirming or updating dependant information. Use an additional piece of paper if necessary.

Type of Coverage: Medical Dental Vision Care & Hearing Aid Plan (VCHAP) Single Family

Reason for Change (Marriage/Divorce/Adoption) **Effective Date of Change (DD/MM/YYYY)**

D | D | M | M | Y | Y | Y | Y

1. SPOUSAL INFORMATION

Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	D D M M Y Y Y Y
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/> Confirm <input type="checkbox"/> Male <input type="checkbox"/> Female		

2. DEPENDANT INFORMATION

[1] Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	D D M M Y Y Y Y
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/> Confirm <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependant <input type="checkbox"/> Full Time Student		
[2] Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	D D M M Y Y Y Y
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/> Confirm <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependant <input type="checkbox"/> Full Time Student		
[3] Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	D D M M Y Y Y Y
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/> Confirm <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependant <input type="checkbox"/> Full Time Student		
[4] Last Name	First Name and Initials	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	D D M M Y Y Y Y
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete <input type="checkbox"/> Confirm <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependant <input type="checkbox"/> Full Time Student		

COORDINATION OF BENEFITS

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

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

Medical

Single Family Waived

Dental

Single Family Waived

Vision/Hearing

Single Family Waived

Name of Spouse's Insurance Carrier

Spouse's Plan No.

Spouse's ID No.

CHANGE LIFE INSURANCE BENEFICIARY DESIGNATION TO

Last Name

First Name and Initials

Social Insurance Number

Relationship to You

E-mail Address

Home Telephone Number

Business Telephone Number

Home Address: Number and Street

Apt. No.

City/Town

Province

Postal Code

PRIVACY

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

AUTHORIZATIONS AND DECLARATIONS

I hereby apply for changes in 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 as a unique number where it is required to protect pensioner privacy and confidentiality in the administration of the plan
- Great-West Life, any healthcare provider, OPTrust, other insurance or re-insurance companies, administrators or government benefits or other benefit programs, other organizations, or service providers working with Great-West 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 his or her behalf. I agree that a photocopy or electronic copy of this "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.

Pensioner's Signature

Date Signed (DD/MM/YYYY)