

PLAN ADMINISTRATOR STATEMENT

I Administrative information <i>(please print)</i>			
Policyholder name	Policy no.	Division no.	Certificate no.
Participant surname	Given name(s)	Initial	Date of birth <i>(YYYY/MM/DD)</i>

PARTICIPANT STATEMENT

II Changes requested
I wish <input checked="" type="checkbox"/> <ul style="list-style-type: none"> <input type="checkbox"/> to cover my dependents (please complete Sections III, IV and V) <input type="checkbox"/> to add a dependent, cancel a dependent or correct dependent information (please complete Section IV) <input type="checkbox"/> to request individual coverage (please complete Section III) <input type="checkbox"/> to advise of a change in my spouse's group insurance plan (please complete Section V) <input type="checkbox"/> to cancel or reinstate health care and/or dental care benefits (please complete Sections V and VI) <input type="checkbox"/> to change my beneficiary designation (please complete Section VII) <input type="checkbox"/> to advise of a change of name (please complete Section X)

III Change of coverage
<input type="checkbox"/> Individual coverage <i>(only the participant is covered)</i> <input type="checkbox"/> Family coverage <i>(the participant and his/her eligible dependents are covered)</i>
Specify reason for requesting dependent coverage, adding a dependent or terminating spouse's insurance coverage.
<input type="checkbox"/> Marriage Date of marriage <i>(YYYY/MM/DD)</i> <input type="checkbox"/> Cohabitation Start date of cohabitation period <i>(YYYY/MM/DD)</i> <input type="checkbox"/> Birth of 1 st child Child's date of birth <i>(YYYY/MM/DD)</i>
<input type="checkbox"/> Termination of coverage provided under spouse's group insurance plan <input type="checkbox"/> Health care <input type="checkbox"/> Dental care
Reason for termination: _____ Date of termination <i>(YYYY/MM/DD)</i> _____
<input type="checkbox"/> Other (specify): _____
Participant signature _____ Date <i>(YYYY/MM/DD)</i> _____

IV Information on your dependent(s)									
Specify <input checked="" type="checkbox"/> Addition <input type="checkbox"/> Cancellation <input type="checkbox"/> Correction									
	Surname	Given name(s)	Gender		Date of birth <i>YYYY/MM/DD</i>	Are your spouse and/or your dependent children covered under another group insurance plan? ¹		Full-time student ²	Total and permanent disability ³
			M	F		Health care	Dental care		
			<input type="checkbox"/>	<input type="checkbox"/>	<i>YYYY/MM/DD</i>	Yes	No	Yes	No
Spouse			<input type="checkbox"/>	<input type="checkbox"/>	<i>/ /</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/>	<input type="checkbox"/>	<i>/ /</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/>	<input type="checkbox"/>	<i>/ /</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/>	<input type="checkbox"/>	<i>/ /</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/>	<input type="checkbox"/>	<i>/ /</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ If your spouse and/or dependent children are covered under another group insurance plan, please complete Section V.
² If you have dependent children who have reached the first age limit stipulated in the contract, please complete Confirmation of school attendance form G2229E and submit it with this form.
³ If you have disabled dependent children who have reached the first age limit stipulated in the contract, please complete Confirmation of total and permanent disability of a dependent child form GE10352 and submit it with this form.

V Information about your spouse's group insurance plan			
Name of your spouse's group insurer	Policy no.	Coverage:	Health care <input type="checkbox"/> Individual <input type="checkbox"/> Family Dental care <input type="checkbox"/> Individual <input type="checkbox"/> Family

VI Exemption request for benefits covered under your spouse's group insurance plan

Cancellation of benefit(s) (please also complete Section V)

I decline health care benefits¹: for myself and my dependents
 for my dependents only

I decline dental care benefits: for myself and my dependents
 for my dependents only

¹ Pursuant to An Act respecting prescription drug insurance, Québec residents must provide medical coverage for themselves and their dependents unless this coverage is provided under the spouse's group insurance plan.

Participant signature

Date (YYYY/MM/DD)

Reinstatement of benefit(s) (please also complete Section V)

I am no longer covered under my spouse's group insurance plan. I hereby request reinstatement of:

Health care benefits¹: for myself only
 for myself and my dependents

Dental care benefits: for myself only
 for myself and my dependents

¹ Pursuant to An Act respecting prescription drug insurance, Québec residents must provide medical coverage for themselves and their dependents unless this coverage is provided under the spouse's group insurance plan.

Date of termination of coverage for health and/or dental care benefits under my spouse's group insurance plan:

Date (YYYY/MM/DD)

Reason for termination:

Participant signature

Date (YYYY/MM/DD)

VII Change of beneficiary designation

Standard Life records beneficiary designations or changes of beneficiaries, but declines any responsibility as to their validity.

This beneficiary designation applies to all life insurance benefits under the policy.

Beneficiary surname

Given name

Relationship to participant

If the designated beneficiary is legal heirs or estate, please write in full "Legal heirs" or "Estate" and do not provide name(s), given name(s) or relationship to participant. If you wish to designate a contingent beneficiary, please complete the Beneficiary Designation form GE9874.

In accordance with the terms and conditions of the above-mentioned group insurance policy, I, the undersigned, hereby revoke any previous designation of beneficiary and name the above-mentioned person as my beneficiary entitled to receive any amount payable under this policy upon my death. If this beneficiary predeceases me and I do not have a contingent beneficiary, the death benefit will be payable to my estate. An irrevocable designation cannot be changed unless the beneficiary, aged 18 or over, signs a waiver of rights.

Participant signature

Date (YYYY/MM/DD)

VIII Québec participants (to be completed if beneficiary is your spouse – marriage or civil union)

In Québec, the designation of a spouse, excluding common-law spouse, as beneficiary is irrevocable unless otherwise specified. If you designate your spouse as beneficiary, Standard Life recommends that you make a revocable designation in order to facilitate any future request for a change of beneficiary. An irrevocable designation cannot be changed unless the beneficiary, aged 18 or over, signs a waiver of rights.

Please sign in the box corresponding to your choice ONLY IF you designate your SPOUSE as beneficiary.

This beneficiary designation is **revocable**

This beneficiary designation is **irrevocable**

OR

Participant signature

Participant signature

IX Declaration appointing Trustee (to be completed if beneficiary is under legal age)

I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under legal age and I declare that the receipt of such Trustee shall be valid discharge to Standard Life of the amount so paid. I also hereby authorize such Trustee at his/her discretion to apply on behalf of such beneficiary the whole or any portion of such amount and the income derived therefrom for the care, maintenance, education, advancement in life or other benefit of such beneficiary.

Participant signature

Date (YYYY/MM/DD)

X Name change

New surname

New given name(s)

Reason for change Marriage Correction Other (specify) :

Participant signature

Date (YYYY/MM/DD)