canada life™

GROUP INSURANCE ADJUSTMENTS

PLAN SPONSOR		
PLAN NUMBER	DIV. NO.	DATE

(Please Print)
COMPLETED BY: _____

AREA CODE & PHONE #: (_____) _____

TO: THE CANADA LIFE ASSURANCE COMPANY
PO BOX 6000
WINNIPEG MB R3C 3A5
FAX #: 204.946.4101
ATTN: MEMBER ADMINISTRATION

PLAN MEMBER NAME	I.D. NUMBER (When Known)	REASON CODE (See Below)	EFFECTIVE DATE OF CHANGE(S)	PLEASE INCLUDE DETAILS

PREPARE IN DUPLICATE
1 COPY TO GWL
1 COPY FOR YOUR RECORDS

*** REASON CODES 1, 12 & 16 ARE NOT REQUIRED FOR DIVISIONS MAINTAINED FOR CLAIMS PURPOSES ONLY**

REASON CODES (Please insert the applicable Reason Code for each plan member in the column above)

1 – EARNINGS CHANGE*
2 – DEPENDANT - Add coverage [Attach Group Coverage Change Form M6190 or M6190(f)]
3 – DEPENDANT - Delete coverage
4 – CLASS CHANGE
5 – WAIVED BENEFITS [Attach Group Coverage Change Form M6190 or M6190(f)]
6 – TERMINATION - Layoff or Leave of Absence
7 – TERMINATION - Employment
8 – TERMINATION - Plan Member cancels [Attach Group Coverage Change Form M6190 or M6190(f)]
9 – DIVISION TRANSFER
10 – NEW PLAN MEMBER [Attach Application for Group Coverage Form M6191 or M6191(f)]
11 – REINSTATEMENT [Attach Group Coverage Change Form M6190 or M6190(f)]
12 – BENEFICIARY CHANGE [Attach Group Coverage Change Form M6190 or M6190(f)]*
13 – NAME CHANGE [Attach Group Coverage Change Form M6190 or M6190(f)]
14 – OCCUPATION CHANGE
15 – PROVINCE OF RESIDENCE CHANGE
16 – PROVINCE OF WORK CHANGE*
17 – LOST OR STOLEN DRUG CARD
18 – REPLACE OR ADDITIONAL DRUG CARD
19 – RETIREMENT DATE
20 – OTHER (Describe briefly)

M5726-1/20

Clear