



REQUEST FOR CHANGE OF WAITING PERIOD ADA INCOME PROTECTION PLAN

ADA Member Name: _____

ADA Member Number: _____ Date of Birth: _____

Daytime Phone: _____ Fax: _____

E-mail: _____

Please complete this form and return it to Great-West by fax or mail. Your waiting period change will go into effect on the date your next renewal premium is due, either May 1 or October 1 if you have selected semi-annual billing, or if you have selected monthly Autopay withdrawal, on the first day of the month following receipt of your request. Note: Proof of good health will be required ONLY IF you are requesting a shorter waiting period.

This change affects: All of my current coverage
 The portion of my coverage that currently has a waiting period of _____ days

New Waiting Period: 180 days
 90 days
 60 days
 30 days

Signature of Member: _____ Date: _____

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

800-568-2001 • 303-737-4843 fax • P.O. Box 340, Denver CO 80201 • ada@gwl.com