THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY COVERAGE DETAIL

This application consists of two parts: *The Evidence of Insurability Coverage Detail* form and *Medical & Lifestyle Questionnaire.*

INSTRUCTIONS Please complete in INK only (blue or black)

Plan Administrator:
1. Complete, sign and date the Coverage Detail section.
2. Retain a copy of the completed section for your files.
3. Forward the original copy, along with the Medical & Lifestyle Questionnaire, to the employee.

Employee:
1. Review, sign and date the Coverage Detail section.
2. Complete Medical & Lifestyle Questionnaire.
3. Make a copy of both sections for your records and send the **ORIGINALS** to Great-West Life.

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
PO BOX 6000
WINNIPEG MB R3C 3A5
TEL 204.946.8554
TTY LINE 1.800.990.6654
(available for the deaf or hard of hearing)

Name of Group Policyholder (Employer)	Group Policy No.	Division No.

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____	Employee Last Name	First Name	Middle Name	Gender ☐ Male ☐ Female

Date of Birth			Employee's Annual Earnings	ID No.	Class
Month	Day	Year	$		

PURPOSE OF THIS APPLICATION (Make sure you only complete the applicable sections.)

☐ **LATE APPLICANT (ELIGIBILITY PERIOD EXPIRED):**
Check coverage currently being applied for

	Employee	Spouse	Children
Basic Life	☐	☐	☐
Healthcare	☐	☐	☐
*Dental	☐	☐	☐
Short Term Disability	☐		
Long Term Disability	☐		

***Note:** Dental restrictions may apply. Refer to your employee booklet or contract.*

☐ **COVERAGE GREATER THAN THE NON-EVIDENCE MAXIMUM (NEM):**

Coverage	Current Amount	New Total Amount Applied for
Life Insurance	$_____	$_____
Long Term Disability	$_____	$_____
Short Term Disability	$_____	$_____

☐ **Supplemental Life:** ☐ **Basic Life:**

Existing Amount: $_____
New Amount Applied for: $_____
New Total Amount: $_____

☐ **OPTIONAL LIFE INSURANCE**

EMPLOYEE OPTIONAL LIFE INSURANCE	SPOUSAL OPTIONAL LIFE INSURANCE	CHILD OPTIONAL LIFE INSURANCE
Existing Optional Life: $_____	Existing Optional Life: $_____	Existing Optional Life Amount: $_____
Additional Amount Applied for: $_____	Additional Amount Applied for: $_____	Additional Amount Applied for: $_____
New Total Applied for: $_____	New Total Applied for: $_____	New Total Applied for: $_____
If plan is % of salary, state percent applied for_____	If plan is an option or choice, state _____	If plan is an option or choice, state _____

OPTIONAL LIFE BENEFICIARY DESIGNATION

First Name _____ Last Name _____ Relationship to employee _____

The Beneficiary for the spousal or child coverage shall be the employee if living, otherwise the estate. I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

NOTE: Where Quebec law applies: and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable", below.

I hereby make the above beneficiary designation:

☐ Revocable, I may change this beneficiary at any time

An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.

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☐ **OPTIONAL FLEX BENEFITS**

EMPLOYEE OPTIONAL LONG TERM DISABILITY INSURANCE

	$ Amount
Current % of Monthly Benefit: _____ %	_____
New Option: _____ % of monthly earnings	_____
Total Monthly Benefit Amount:	_____

EMPLOYEE OPTIONAL SHORT TERM DISABILITY INSURANCE

	$ Amount
Current % Weekly Benefit: _____ %	_____
New Option: _____ % of weekly earnings	_____
Total Weekly Benefit Amount:	_____

☐ **OPTIONAL CRITICAL ILLNESS INSURANCE**

New employees and their spouses may elect, without evidence, within 31 days of eligibility, Optional Critical Illness Insurance up to the Non-Evidence Maximum (NEM) amount for their group plan. The NEM must be confirmed by plan administrator. (Step 4 below).

****Medical questionnaire not required if applying for the NEM amount.** Overall maximum for optional critical illness insurance is $250,000.

EMPLOYEE OPTIONAL CRITICAL ILLNESS INSURANCE

1. Existing Optional Critical Illness Amount: $ _____
2. Amount Applied for: $ _____
3. New Amount Applied for: $ _____ (1+2)
4. **Amount Available Without Evidence: $** _____
5. Amount Applied for With Medical Evidence: $ _____ (3-4)

SPOUSAL OPTIONAL CRITICAL ILLNESS INSURANCE

1. Existing Optional Critical Illness Amount: $ _____
2. Amount Applied for: $ _____
3. New Amount Applied for: $ _____ (1+2)
4. **Amount Available Without Evidence: $** _____
5. Amount Applied for With Medical Evidence: $ _____ (3-4)

Plan Administrator's Signature: _____ Date: _____ mm/dd/yyyy

Print Plan Administrator's Name: _____ Plan Administrator's Phone No.: _____

Employee's Signature: _____ Date: _____ mm/dd/yyyy

NOTICE ABOUT MIB INC.

Important Notice

YOUR PERSONAL INFORMATION WILL BE TREATED AS CONFIDENTIAL. GREAT-WEST LIFE OR ITS REINSURER(S) MAY, HOWEVER, MAKE A BRIEF REPORT TO THE MIB INC., A NON-PROFIT MEMBERSHIP ORGANIZATION OF LIFE INSURANCE COMPANIES WHICH OPERATES AN INFORMATION EXCHANGE ON BEHALF OF ITS MEMBERS. IF YOU APPLY TO ANOTHER BUREAU MEMBER COMPANY FOR LIFE OR HEALTH INSURANCE OR SUBMIT A CLAIM FOR BENEFITS TO SUCH A COMPANY, THE BUREAU WILL UPON REQUEST SUPPLY THE COMPANY WITH THE INFORMATION IT MAY HAVE.

GREAT-WEST LIFE OR ITS REINSURER(S) MAY ALSO RELEASE INFORMATION TO OTHER LIFE INSURANCE COMPANIES TO WHOM YOU APPLY FOR LIFE OR HEALTH INSURANCE, OR TO WHOM YOU SUBMIT A CLAIM FOR BENEFITS. THE COMPANY WILL NOT, HOWEVER, REVEAL TO ANOTHER COMPANY OR TO THE BUREAU THE ACTION TAKEN ON THE BASIS OF YOUR CURRENT REQUEST FOR INSURANCE.

IF YOU WISH TO SEE THE INFORMATION IN YOUR BUREAU FILE OR HAVE IT CORRECTED, PLEASE CONTACT THE BUREAU'S INFORMATION OFFICE AT:

SUITE 501
330 UNIVERSITY AVENUE
TORONTO ON M5G 1R7
TEL 416.597.0590

Protecting Your Personal Information

At **The Great-West Life Assurance Company**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West 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 Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information for the purposes of determining your insurability and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

THE Great-West Life ASSURANCE COMPANY

MEDICAL & LIFESTYLE QUESTIONNAIRE

This application consists of two forms:

The Evidence of Insurability Coverage Detail form and *Medical & Lifestyle Questionnaire.*

INSTRUCTIONS Employee:
Please complete in INK only (blue or black)

1. Complete, sign and date the Medical & Lifestyle Questionnaire.
2. **Spousal information is only required if you are applying for dependant coverage.**
3. Submit **ORIGINALS** of the Medical & Lifestyle Questionnaire and the Evidence of Insurability Coverage Detail section to Great-West Life.

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
PO BOX 6000
WINNIPEG MB R3C 3A5
TEL 204.946.8554
TTY LINE 1.800.990.6654
(available for the deaf or hard of hearing)

Name of Group Policyholder (Employer)	Group Policy No.	Division No.

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____

Employee Last Name | First Name | Middle Name | Gender ☐ Male ☐ Female

Date of Birth: Month | Day | Year

Occupation: _____

Job Duties: _____

Email Address: **NOTE:** if you provide your email address we may use it to communicate with you about this Application.

Home Mailing Address | Street | City | Province | Postal Code

Home Phone Number (_____) _____
Best time to call ☐ Day ☐ Evening

Work Phone Number (_____) _____
Best time to call ☐ Day ☐ Evening

SPOUSE INFORMATION (if applicable).

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____

Spouse Last Name | First Name | Middle Name | Gender ☐ Male ☐ Female

Date of Birth: Month | Day | Year

Occupation: _____

Job Duties: _____

Email Address: **NOTE:** if you provide your email address we may use it to communicate with you about this Application.

Home Phone Number (_____) _____
Best time to call ☐ Day ☐ Evening

Work Phone Number (_____) _____
Best time to call ☐ Day ☐ Evening

CHILD INFORMATION (if applicable). If you require more space, complete additional form.

	FIRST NAME	**LAST NAME**	Gender	Date of Birth Month	Day	Year
Child (1)			☐ Male ☐ Female			
Child (2)			☐ Male ☐ Female			
Child (3)			☐ Male ☐ Female			

Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. If extra space is required, please attach a separate sheet of paper and provide the number of the question you are addressing. EE=Employee SP=Spouse CH=Child(ren)

		Yes	No	
1. Do you now have or have you ever had: cancer, heart disease, diabetes, arthritis, any neurological, psychiatric, intestinal or respiratory disorders, or any other chronic medical condition(s)?	EE	☐	☐	Please describe medical condition, including the date of onset and duration.
	SP	☐	☐	
	CH	☐	☐	
2. In the last 12 months have you been taking any prescription medication?	EE	☐	☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
	SP	☐	☐	
	CH	☐	☐	
3. Have you ever been advised to drink less alcohol by your physician, or used drugs, including marijuana, for non-medicinal reasons in the last 10 years?	EE	☐	☐	If Yes, please provide details of when, which product used and frequency of use per week.
	SP	☐	☐	
	CH	☐	☐	

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Personal Medical History and Lifestyle Information (con't)

4. Have you ever stayed overnight in a hospital?		Yes / No	Please provide approximate year, duration of stay and medical diagnosis.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
5. Have you ever tested positive for hepatitis or HIV?		Yes / No	Please describe which test, why you had it and when.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
6. Have you ever had an MRI or CT scan?		Yes / No	Please provide approximate year, describe for what reason(s) and the results.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
7. Have you ever had an application for disability or life insurance declined or modified?		Yes / No	Please provide approximate year and describe for what reason(s).
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
8. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?		Yes / No	Please provide the approximate date that you left work, duration off work and medical condition.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
9. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 8?		Yes / No	Please provide date and describe the medical condition, if not already described above.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
10. Have you gained or lost more than 10 pounds in the last 12 months?		Yes / No	Please provide amount of weight loss or gain and reason.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
11. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?		Yes / No	Please describe the reason.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
12. Do you have a regular family physician? If yes, please advise (in section to the right) Physician's name, address and date and reason of last appointment.		Yes / No	
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
13. Have you been referred to any medical specialists in the last 2 years?		Yes / No	Please provide the name of specialist, type of specialty and medical reason for visit.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	

14. Current height and weight:

EMPLOYEE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds

SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds

15. Within the past 12 months have you smoked or used cigarettes, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts, or tobacco, or nicotine in any other form?		Yes / No	Please provide which product you use, how much/many per day.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
16. Do you drink alcohol?		Yes / No	Please provide type of alcohol and quantity per week.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?		Yes / No	Please describe the type and frequency of the activity.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	

18. Please describe weekly exercise including type of activity, duration and frequency.

Family History

19. For each applicant, do your parents, brothers or sisters, spouse or children suffer or have suffered from any of the following: cancer, heart disease, huntington's chorea, polycystic kidney disease, diabetes, mental illness, substance abuse or any chronic and/or hereditary medical condition?
Employee: ☐ **Yes** ☐ **No** **Spouse:** ☐ **Yes** ☐ **No** **Children:** ☐ **Yes** ☐ **No**
If yes, please complete the appropriate section below. Use extra paper if required.

Employee (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness

Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness

Please provide any additional information that you feel is important:

_____

_____

AUTHORIZATION AND DECLARATIONS

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan;
- Great-West Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application;
- Great-West Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Great-West Life to communicate with me about this application using the email address I have provided;
- My plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I am actively at work on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- I have retained a copy of this application;
- If applying for coverage for dependents, I am authorized to act on their behalf;
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the effective date of any coverage approved by Great-West Life must be reported to Great-West Life. I understand that if I fail to do so, any coverage granted may be void.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be void. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of Great-West Life, I am not insurable for all or part of that benefit.

For Quebec Applicants: I request that all communication and documents be in English.
Je demande à ce que toutes les communications et tous les documents soient en anglais.

Employee Signature _____ Date Signed _____
mm/dd/yyyy

Spouse Signature _____ Date Signed _____
mm/dd/yyyy