

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 and send both sections 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. 166269		Division No.		Class		
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____		Employee Last Name				First Name		Middle Name		
Home Mailing Address				Street				City		Province
Postal Code		Date of Birth		Home Phone No.		Business Phone No.				
		Month	Day	Year	()		()		ext.	
Employee's Annual Earnings: \$					ID No.					
Occupation					Email address					
PURPOSE OF THIS APPLICATION (Make sure you only complete the applicable sections.)										
OPTIONAL LIFE INSURANCE										
<div style="display: flex; justify-content: space-between;"> EMPLOYEE OPTIONAL LIFE INSURANCE SPOUSAL OPTIONAL LIFE INSURANCE CHILDREN OPTIONAL LIFE INSURANCE </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> Employee/Spouse - Units of \$10,000 to maximum of \$300,000 </div> <div style="width: 48%;"> Children - Units of \$5,000 to maximum of \$10,000 per child </div> </div>										
Benefits Requested (Please check off)		A. Existing Amount of Coverage (if applicable)		B. New Amount of Coverage Requested		C. Total Amount of Coverage (A + B)				
<input type="checkbox"/> Optional Life - member		\$ _____		\$ _____		\$ _____				
<input type="checkbox"/> Optional Life - spouse		\$ _____		\$ _____		\$ _____				
<input type="checkbox"/> Optional Life - dependent		\$ _____		\$ _____		\$ _____				
*Child questionnaire only required if applying more than 4 months after first being eligible.										
<div style="display: flex; justify-content: space-between;"> <div> Plan Administrator's Signature: _____ Print Plan Administrator's Name: _____ Employee's Signature: _____ </div> <div> Date: _____ Plan Administrator's Phone No.: _____ Date: _____ </div> </div>										

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.

This application consists of two forms:

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

INSTRUCTIONS
Please complete
in INK only
(blue or black)

- Employee:**
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
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(available for the deaf or hard of hearing)

Name of Group Policyholder (Employer)		Group Policy No. 166269	Division No.	Class
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	<input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> _____	Employee Last Name		First Name Middle Name

Date of Birth: Month _____ Day _____ Year _____ Employee Height? _____ ☐ m/cm ☐ ft/in Employee Weight? _____ ☐ kg ☐ lb

SPOUSE / CHILDREN INFORMATION (if applicable). If you require more space, complete additional form.

	FIRST NAME	LAST NAME	Sex	Date of Birth			Height	Weight
				Month	Day	Year		
Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> m/cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lb
Child (1)			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> m/cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lb
Child (2)			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> m/cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lb
Child (3)			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> m/cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lb

THE FOLLOWING QUESTIONS SHOULD BE ANSWERED FOR EACH INDIVIDUAL WHO IS APPLYING FOR COVERAGE.

IF ANSWER IS YES TO ANY OF THE QUESTIONS, GIVE FULL DETAILS BELOW: (if more space is required, attach another sheet)

***CHILD QUESTIONNAIRE ONLY REQUIRED IF APPLYING MORE THAN 4 MONTHS AFTER FIRST BEING ELIGIBLE.**

Spouse's Occupation: _____

Have you, your spouse, or your children:

	EMPLOYEE		SPOUSE		CHILDREN	
	Yes	No	Yes	No	Yes	No
1. had any ailment, injury or illness in the past five years which caused the individual to be away from work or school for 10 days or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. ever had high or low blood pressure, high cholesterol (and if so, advise if any treatment and most recent level), pain or tightness in the chest, or any heart disorder including disorders of the circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. ever had cancer, disorders of the blood, diabetes, hepatitis, liver disorder, kidney, respiratory or intestinal disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. ever had convulsions, loss of consciousness, fainting spells, severe headaches, nervous breakdown, mental illness, anxiety, depression, chronic fatigue syndrome, cerebral palsy, stroke, or any disorder of the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. ever had backache, rheumatic fever, rheumatism, arthritis, paralysis, fibromyalgia, or disorder of the muscles or bones, including joints, spine and skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. had any disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. had AIDS or other disorder of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. ever been in a hospital, sanitarium or other institution for treatment or observation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. any reason to believe you will require medical or surgical treatment during the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. ever taken drugs, other than for medical purposes, been advised to drink less alcohol or received treatment for drug addiction or alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. ever had any serious illness or injury since childhood not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. had X-rays, electrocardiograms, blood or other special tests, for other than regular medical checkups in the last five years? (indicate the test results below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. ever made a claim or received a pension, payments or compensation benefits for an accident or sickness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. ever had an application for insurance declined, postponed or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. been involved in the operation of an aircraft, or participated in hazardous activities such as motorized racing, hang gliding, parachuting or scuba diving? (If "yes", circle the appropriate activity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. smoked cigarettes in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. have your parents, brothers or sisters ever had cancer, diabetes, heart or kidney disease or any hereditary disorder? (If "yes", provide complete details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. had any change in weight in the past year? (If "yes", indicate who)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Amount gained: _____ Amount lost: _____ Reason: _____

DETAILS					
QUES. NO.	NAME	TEST, INJURY, ILLNESS, OPERATION OR COMPLICATION	DATE OF		FULL DETAILS (INCLUDING DOCTORS' NAMES AND ADDRESSES)
			ONSET	RECOVERY	

AUTHORIZATION AND DECLARATIONS
<p>I authorize:</p> <ul style="list-style-type: none"> • 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. • my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable. <p>I certify or confirm that:</p> <ul style="list-style-type: none"> • 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; <p>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.</p> <p>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.</p> <p><i>For Quebec Applicants:</i> 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.</p> <p>Employee Signature _____ Date Signed _____</p> <p>Spouse Signature _____ Date Signed _____</p>