

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

- ▶ Sections 1-3: To be completed first by the Plan Administrator. Retain a copy of the completed section for your files.
- ▶ Section 3: To be reviewed, signed and dated by the employee; including completion of the smoking and beneficiary declarations (if applicable).
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- ▶ Employee to send the form directly to Great-West Life.

Section #1				Employee's Information		Completed by Plan Administrator	
Name of Group Policyholder (Employer)			Policy No.		Division No.		Benefit Class
<div style="display: flex; justify-content: space-between;"> <div style="width: 15%;"> Title <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____ </div> <div style="width: 30%;">Employee Last Name</div> <div style="width: 20%;">First Name</div> <div style="width: 15%;">Middle Initial</div> <div style="width: 20%;">ID No.</div> </div>							
Date of Employment MMM/DD/YYYY		Annual Earnings		Plan Administrator's Name		Plan Administrator's Phone No. XXX-XXX-XXXX	
						Plan Administrator's Email Address	
Plan Administrator's Authorization						Date Authorized MMM/DD/YYYY	
<input type="checkbox"/> I hereby certify that the information on this Coverage Detail form is accurate.							

Section #2		Reason for Application		Completed by Plan Administrator	
<input type="checkbox"/> New Enrolment					
<input type="checkbox"/> *Late Applicant (Eligibility Period Expired)		Complete section 3 (A)		*Application for Group Coverage, or Group Coverage Change Form, must be included.	
<input type="checkbox"/> Increase Coverage		Complete applicable portion of Section 3 (B), (C) or (D)			
<input type="checkbox"/> Annual Enrolment - Effective Date: MMM/DD/YYYY		Complete applicable portion of Section 3 (B), (C) or (D)			

Section #3		Benefits Requested		Completed by Plan Administrator	
Section #3 (A)		For Late Applicants			
	Employee	Spouse	Children		
Basic Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Dental Restrictions may apply. Refer to employee booklet or contract.	
Short Term Disability	<input type="checkbox"/>				
Long Term Disability	<input type="checkbox"/>				
Section #3 (B)		Excess Coverage			
	<input type="checkbox"/> Basic <input type="checkbox"/> Supplemental	Current Amount	New Total Amount Applied For		
Life		<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Short Term Disability		<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Long Term Disability		<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Section #3 (C)		Optional Flex Benefits			
	Current: % of earnings	Current Amount (\$)	New Option: % of earnings	New Amount (\$)	
Short Term Disability	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
Long Term Disability	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Section #3**Benefits Requested ...continued****Section #3 (D)****Optional Coverage**

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 3 below).

Applicant	(1) Current Amount	(2) New Total Amount Applied for	(3) Amount Available without Evidence (NEM) (Confirm with Plan Administrator)	(4) Amount Applied for with Medical Evidence (Steps 2-3)	If plan is % of salary, total % applied for:
Employee					
Optional Life					
Optional Critical Illness					
Spouse					
Optional Life					
Optional Critical Illness					
Child					
Optional Life					
Optional Critical Illness					

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

Smoking Declaration**Completed by Member**

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
EMPLOYEE	<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE	<input type="checkbox"/>	<input type="checkbox"/>

Optional Life Beneficiary Designation**Completed by Member**

This section must be completed to designate a beneficiary for your life benefits, if applicable. **The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed. Please print clearly, in INK.**

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

First Name	Last Name	Middle Initial	Percent allocated	Relationship to employee

To be divided as follows: ☐ As per the percentage indicated above, or ☐ In equal shares to the survivor(s)

► 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.

Plan Member's Signature

Signature	Date
	MMM/DD/YYYY

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Section #4 Member and Dependant Details **Completed by the Member**

Employee Information

Name of Group Policyholder (Employer)				Policy No.	
Title		Employee Last Name		First Name	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____					
				Middle Initial	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		Occupation		Job Duties	
MMM/DD/YYYY					
Home Mailing Address		Street	City	Province	Postal Code
Email Address					
NOTE: If you provide your email address, we may use it to communicate with you about this application.					
Home Phone No.		Best time to call		Alternate Contact Number	
XXX XXX-XXXX				XXX XXX-XXXX	
		<input type="checkbox"/> Day <input type="checkbox"/> Evening		Extension XXXX	
				Best time to call <input type="checkbox"/> Day <input type="checkbox"/> Evening	

Spouse Information (if applicable) - only required if you are applying for dependant coverage.

Title		Spouse Last Name		First Name	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____					
				Middle Initial	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		Occupation		Job Duties	
MMM/DD/YYYY					
Email Address					
NOTE: If you provide your email address, we may use it to communicate with you about this application.					
Home Phone No.		Best time to call		Alternate Contact Number	
XXX XXX-XXXX				XXX XXX-XXXX	
		<input type="checkbox"/> Day <input type="checkbox"/> Evening		Extension XXXX	
				Best time to call <input type="checkbox"/> Day <input type="checkbox"/> Evening	

Child Information (if applicable) - only required if you are applying for dependant coverage.

	Child Last Name	Child First Name	Gender	Date of Birth
Child (1)			<input type="checkbox"/> Male <input type="checkbox"/> Female	MMM/DD/YYYY
Child (2)			<input type="checkbox"/> Male <input type="checkbox"/> Female	MMM/DD/YYYY
Child (3)			<input type="checkbox"/> Male <input type="checkbox"/> Female	MMM/DD/YYYY
Child (4)			<input type="checkbox"/> Male <input type="checkbox"/> Female	MMM/DD/YYYY

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Section #5

Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

EE = Employee SP = Spouse
CH = Child(ren)

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)?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please describe medical condition, including the date of onset and duration.
2. Have you ever tested positive for hepatitis or HIV?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please describe which test, why you had it and when.
3. Have you ever had an MRI or CT scan?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide approximate year, describe for what reason(s) and the results.
4. Have you ever stayed overnight in a hospital?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide the approximate date that you left work, duration off work and medical condition.
6. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 5?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide date and describe the medical condition, if not already described above.
7. Have you ever had an application for insurance declined or modified?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide approximate year and describe for what reason(s).
8. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please describe the reason.
9. In the last 12 months have you been taking any prescription medication?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
10. Have you ever been advised to drink less alcohol by your physician, or used drugs (including marijuana) for non-medical reasons in the last 10 years?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide details of when, which product used, and frequency of use per week.
11. Do you drink alcohol?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide type of alcohol and quantity per week.
12. 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 EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide which product you use, how much/many per day.

Section #5 Personal Medical History and Lifestyle Information ...continued

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

EE = Employee SP = Spouse
CH = Child(ren)

13. Have you gained or lost more than 10 pounds in the last 12 months?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please specify weight <u>loss</u> or <u>gain</u> , amount of change in weight, and reason.
14. Current height and weight: EMPLOYEE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds		
15. 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 <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	
16. Have you been referred to any medical specialists in the last 2 years?	Yes No EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please provide the name of specialist, type of specialty and medical reason for visit.
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 EE <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/> CH <input type="checkbox"/> <input type="checkbox"/>	Please describe the type and frequency of the activity.
18. Please describe weekly exercise including type of activity, duration and frequency.		

Family History - You should not tell us about any genetic test which you have had.

19. For each applicant, do your parents, brothers or sisters, spouse or children suffer or have suffered from any of the following:

- | | | | |
|---|-----------------|------------------------|---|
| • Alzheimer's Disease | • Cancer | • Huntington's chorea | • Polycystic kidney disease |
| • Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease) | • Dementia | • Motor Neuron disease | • Stroke |
| | • Diabetes | • Multiple Sclerosis | • and/or any other hereditary medical condition |
| | • Heart Disease | • Parkinson's Disease | |

► **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 (including specific type, if known)
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Please provide any additional information that you feel is important:

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.

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 _____ MMM/DD/YYYY

Spouse Signature _____ Date Signed _____ MMM/DD/YYYY

Mailing Address

The Great-West Life Assurance Company
Group Medical Underwriting
PO Box 6000
Winnipeg MB R3C 3A5
Email: groupmed@gwl.ca
TTY Line 1.800.990.6654 (available for the deaf or hard of hearing)

Additional Details

This page is to be used if you require **extra space to respond to a question**.
Provide the number of the question you are addressing.

EE = Employee SP = Spouse
CH = Child(ren)

Question #	Details