

**EVIDENCE OF INSURABILITY**

**COVERAGE DETAIL**



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

- INSTRUCTIONS**
- Plan Administrator:**
1. Complete, sign and date the Coverage Detail form.
  2. Retain a copy of the completed form 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 form.
  2. Complete **Medical & Lifestyle Questionnaire** and send both forms to Great-West.
- THE GREAT-WEST LIFE ASSURANCE COMPANY  
GROUP MEDICAL UNDERWRITING  
P.O. BOX 6000  
WINNIPEG, MANITOBA R3C 3A5  
TELEPHONE (204) 946-8554

Name of Group Policyholder (Employer)		Group Policy No.	Division No.
<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.	Class	Occupation
Is this employee currently insured for any benefits under this group insurance plan: <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please indicate type and amount of coverage (if applicable):			
		Basic Life	\$ _____
		LTD	\$ _____
		STD	\$ _____
		Health	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PURPOSE OF THIS APPLICATION (Make sure you only complete the applicable sections.)</b>			
<input type="checkbox"/> <b>LATE APPLICANT (ELIGIBILITY PERIOD EXPIRED):</b>			
Check coverage currently being applied for			
	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"/>
Short Term Disability	<input type="checkbox"/>		
Long Term Disability	<input type="checkbox"/>		
<i>* Note: Dental restrictions may apply. Refer to your employee booklet or contract.</i>			
<input type="checkbox"/> <b>COVERAGE GREATER THAN THE NON-EVIDENCE MAXIMUM (NEM):</b>		<input type="checkbox"/> <b>SUPPLEMENTAL LIFE INSURANCE:</b>	
<b>Coverage</b>	<b>Current Amount</b>	<b>New Total Amount Applied for</b>	Current Amount: \$ _____
Life Insurance	\$ _____	\$ _____	New Total Amount Applied for: \$ _____
Long Term Disability	\$ _____	\$ _____	<input type="checkbox"/> <b>OTHER COVERAGE (PLEASE SPECIFY INCLUDING AMOUNT):</b> _____
Short Term Disability	\$ _____	\$ _____	
<input type="checkbox"/> <b>OPTIONAL LIFE INSURANCE</b>			
EMPLOYEE OPTIONAL LIFE INSURANCE:		SPOUSAL OPTIONAL LIFE INSURANCE:	
CHILDREN OPTIONAL LIFE INSURANCE:			
Current Optional Life Amount: \$ _____	Current Optional Life Amount: \$ _____	Current Optional Life Amount: \$ _____	
New Total Amount Applied For: \$ _____	New Total Amount Applied For: \$ _____	New Total Amount Applied For: \$ _____	(each child)
If plan is % of salary, state percent applied for _____ If plan is an option or choice, state _____			
<b>OPTIONAL LIFE BENEFICIARY DESIGNATION</b>		<b>NOTE: WHERE THE CIVIL CODE OF QUEBEC APPLIES,</b> any designation of your spouse as beneficiary is irrevocable ("spouse" here includes any person recognized by law, in this context, as equivalent to your spouse), unless you stipulate the designation to be revocable, by checking the box marked revocable.	
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 make the designation: <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable 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.	
<b>Trustee</b> – recommended for any beneficiary under age 18, or any beneficiary who may not be able to give a valid discharge.			
<b>DO NOT USE THIS SECTION IF THERE IS A WRITTEN TRUST AGREEMENT.</b>			
I appoint _____			
Relationship to life to be insured _____			
as trustee to receive, in trust, benefits under the Great-West Life group policy referred to above. This appointment applies to benefits payable to any beneficiary designated under this contract who, at the time benefits are payable, is a minor or lacks legal capacity to give a valid discharge according to the laws of the beneficiary's domicile. Payment of benefits to the trustee discharges Great-West Life to the extent of the payment.			
I authorize the trustee in his or her sole discretion to use the benefits for the education or maintenance of the beneficiary and to exercise any right of the beneficiary under the group policy. The trustee may, in addition to the investments authorized for trustees, invest in any product of, or offered by, Great-West Life or its affiliated financial institutions. The trust for any beneficiary will terminate, once that beneficiary is both of age of majority and has legal capacity to give a valid discharge, and I direct the trustee to deliver at that time to the beneficiary, the assets held in trust for that beneficiary. I or my personal representative (in Quebec: my tutor, curator, liquidator or mandatary in the event of incapacity) may by writing appoint a new trustee to replace a former trustee.			
<input type="checkbox"/> No trustee desired			
<input type="checkbox"/> <b>OPTIONAL FLEX BENEFITS</b>			
EMPLOYEE OPTIONAL LONG TERM DISABILITY INSURANCE:		EMPLOYEE OPTIONAL SHORT TERM DISABILITY INSURANCE:	
Current % of Monthly Benefit: _____ %	New Option: _____ % of monthly earnings	Current Weekly Benefit: \$ _____	New Option: _____ % of weekly earnings
Total Monthly Benefit Amount: \$ _____		Total Weekly Benefit Amount: \$ _____	
Plan Administrator's Signature: _____ Date: _____		Print Plan Administrator's Name: _____ Plan Administrator's Phone No.: _____	
Employee Signature: _____ Date: _____			

# MEDICAL & LIFESTYLE QUESTIONNAIRE



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

**INSTRUCTIONS**

- Employee:**
1. Complete, sign and date the Medical & Lifestyle Questionnaire.
  2. **Spousal and children 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 form to Great-West.

THE GREAT-WEST LIFE ASSURANCE COMPANY  
 GROUP MEDICAL UNDERWRITING  
 P.O. BOX 6000  
 WINNIPEG, MANITOBA R3C 3A5  
 TELEPHONE (204) 946-8554

**Please print**

Name of Group Policyholder (Employer)		Group Policy No.	Division No.
<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
Date of Birth: Month _____ Day _____ Year _____	Employee Height? _____	<input type="checkbox"/> m/cm <input type="checkbox"/> ft./in	Employee Weight? _____
			<input type="checkbox"/> kg <input type="checkbox"/> 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)**

**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, 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 sports such as motorized racing, hang gliding parachuting, skin or scuba diving? (If "yes", circle the appropriate sport)	<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. 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**

I authorize:

- Great-West, any healthcare provider, my plan administrator, other insurance companies, the Medical Information Bureau, other organizations, or benefit service providers working with Great-West to exchange information, when necessary to determine my insurability and to administer the group benefit plan;
- Great-West to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application.

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 Medical Information Bureau;
- 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 date Great-West makes a decision must be reported to Great-West. 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, 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.

Date Signed: \_\_\_\_\_ Signature of Employee: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Signature of Spouse: \_\_\_\_\_  
 (if spousal coverage applied for)

## NOTICE ABOUT MEDICAL INFORMATION BUREAU

### Important Notice

YOUR PERSONAL INFORMATION WILL BE TREATED AS CONFIDENTIAL. GREAT-WEST OR ITS REINSURERS MAY, HOWEVER, MAKE A BRIEF REPORT TO THE MEDICAL INFORMATION BUREAU, 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 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. THE BUREAU'S INFORMATION OFFICE IS AT 330 UNIVERSITY AVE., TORONTO, ONTARIO M5G 1R7, TELEPHONE (416) 597-0590.

### Protecting Your Personal Information

At Great-West, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West or the offices of an organization authorized by Great-West. We limit access to information in your file to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to provide you with financial services and to administer the group benefit plan.