THE Great-West Life ASSURANCE COMPANY

Great-West Life
your Benefits Solutions People

EVIDENCE OF INSURABILITY FOR GROUP CRITICAL ILLNESS INSURANCE COVERAGE DETAIL

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

INSTRUCTIONS

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
P.O. BOX 6000
WINNIPEG, MANITOBA R3C 3A5
TELEPHONE (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

Home Mailing Address | Street | City | Province

Postal Code | Date of Birth (Month / Day / Year) | Home Phone No. ( ) | Business Phone No. ( ) ext.

Employee's Annual Earnings: $ | ID No. | Class | Occupation

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

☐ **BASIC COVERAGE**

☐ **LATE APPLICANT (ELIGIBILITY PERIOD EXPIRED)**

No. of units or % of salary _____ **Total amount** _____ ☐ **DEPENDENT COVERAGE**

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

Current Amount (if applicable)	Non Evidence Maximum	New Total Amount Applied For
$ _____	$ _____	$ _____

☐ **OPTIONAL COVERAGE**

☐ EMPLOYEE:
Current Amount (if applicable): $ _____
New Total Amount Applied For: $ _____

☐ SPOUSE:
Current Amount (if applicable): $ _____
New Total Amount Applied For: $ _____

Plan Administrator's Signature: _____ Date: _____

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

Employee Signature: _____ Date: _____

NOTICE ABOUT MEDICAL INFORMATION BUREAU

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 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 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 0F 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 AVE., TORONTO, ONTARIO M5G 1R7, TELEPHONE (416) 597-0590.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. 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. We use the personal information to determine your insurabilty and to administer the group benefits plan.

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THE Great-West Life ASSURANCE COMPANY

Great-West Life your Benefits Solutions People

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 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
P.O. BOX 6000
WINNIPEG, MANITOBA R3C 3A5
TELEPHONE (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

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

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

FIRST NAME **LAST NAME**	Sex	Date of Birth Month	Day	Year	Height ☐ m/cm ☐ ft/in	Weight ☐ kg ☐ lb

Do you have any Critical Illness coverage in force or pending? Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

If yes, give details below:

	Amount	Company Name	Issue Date
Employee			
Spouse			

Do you intend to travel, reside or work outside of North America for over 2 months within the next 2 years? Employee ☐ Yes ☐ No

If yes, give details: Spouse ☐ Yes ☐ No

FAMILY HISTORY

Has any parent, brother or sister ever had cancer, or tumours of the breast and or colon, heart disease, stroke, high blood pressure, diabetes, polycystic or other kidney disease, Huntington's chorea, Alzheimer's disease, multiple sclerosis or any other inherited disease?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No If yes, please complete the following:

Relationship to member/spouse	Condition	Age at onset	Age if living	Age at death	Cause of death

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 _____

*All questions shoud be fully completed to avoid delays in the assessment. For questions with **bold print** answered "Yes", please complete appropriate questionnaire on page 4. Use the Details section on the next page to explain all other questions relating to the employee or spouse answered "Yes".*

Have you ever been tested for, treated for, or told you had:	Employee	Spouse
1. **abnormal blood pressure**, ECG, chest pain, angina, heart murmur, heart attack, phlebitis, elevated cholesterol, or any other disease or disorder of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No
2. **ulcers**, jaundice, chronic diarrhea, intestinal bleeding, pancreatitis, hepatitis, liver disease, or any other **disease of the stomach, intestines, rectum or liver**?	☐ Yes ☐ No	☐ Yes ☐ No
3. **asthma, bronchitis**, shortness of breath, emphysema, tuberculosis or any other respiratory disease?	☐ Yes ☐ No	☐ Yes ☐ No
4. abnormal urine, veneral disease, or any disease of the kidneys, bladder, prostate or reproductive organs or breasts?	☐ Yes ☐ No	☐ Yes ☐ No

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5.	**arthritis, back pain**, fibromyalgia, systemic lupus erythematosis, or any other disease, or disorder of the joints, bones or muscles?	☐ Yes ☐ No	☐ Yes ☐ No
6.	epilepsy, paralysis, stroke, Transient Ischemic attacks (TIA) recurrent headaches, dizziness, aneurysm, multiple sclerosis, tingling of limbs, Alzheimer's, Parkinson's or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
7.	**anxiety, stress, depression, fatigue or burnout or any other mental illness**?	☐ Yes ☐ No	☐ Yes ☐ No
8.	diabetes, thyroid or any other glandular disease?	☐ Yes ☐ No	☐ Yes ☐ No
9.	cancer, cyst, tumor, polyp or other growth, skin lesion or any form of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No
10.	anemia, leukemia, or any other disease of the blood or lymph glands?	☐ Yes ☐ No	☐ Yes ☐ No
11.	loss of speech or any disease or disorder of the eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
12.	AIDS or other disorder of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	☐ Yes ☐ No	☐ Yes ☐ No
13.	ever been in a hospital, sanitarium or other institution for treatment or observation?	☐ Yes ☐ No	☐ Yes ☐ No
14.	any reason to believe you will require medical or surgical treatment during the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
15.	X-rays, electrocardiograms, blood or other special tests, for other than regular medical checkups in the last five years? (indicate the test results below)	☐ Yes ☐ No	☐ Yes ☐ No
16.	in the past 5 years, have you used marijuana, cocaine, narcotics, hallucinogenic or other habit-forming drugs?	☐ Yes ☐ No	☐ Yes ☐ No
17.	a) indicate type and average weekly consumption of alcohol. _____		
	b) have you ever been advised to reduce your intake or been treated for **excessive use of alcohol**?	☐ Yes ☐ No	☐ Yes ☐ No
18.	have you had any illness or injury within the past two years which resulted in a continuous absence from work of 10 days or more? If "Yes", state reason and duration of absence in the Details section.	☐ Yes ☐ No	☐ Yes ☐ No
19.	have you taken medication or been treated for or told that you had any physical impairment, condition, disease or disorder not stated in this questionnaire?	☐ Yes ☐ No	☐ Yes ☐ No
20.	Please give date and reason physician was last consulted. Employee _____ Spouse _____		
21.	are you aware of any symptoms or complaints regarding your health for which you have not consulted a physician?	☐ Yes ☐ No	☐ Yes ☐ No
22.	ever made a claim or received pension, payments or compensation benefits for an accident or sickness?	☐ Yes ☐ No	☐ Yes ☐ No
23.	ever had an application for insurance declined, postponed or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
24.	been involved in the operation of an aircraft, or participated in hazardous activities such as motorized racing, hang gliding, parachuting, skin or scuba diving? (If "yes", circle the appropriate sport)	☐ Yes ☐ No	☐ Yes ☐ No
25.	have you used tobacco products within the last year, including nicotine products/patches? If "Yes", give details of type and amount _____	☐ Yes ☐ No	☐ Yes ☐ No
26.	had any change in weight in the past year? (If "yes", indicate who) Amount gained: _____ Amount lost: _____ Reason: _____	☐ Yes ☐ No	☐ Yes ☐ No

DETAILS

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

AUTHORIZATION AND DECLARATIONS

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the Medical Information Bureau, 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.

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 Life makes a decision 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 Québec 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 _____

Spouse Signature _____ Date Signed _____

Blood Pressure

Date first advised blood pressure elevated	Treatment	How long on treatment?	Are you still under treatment?
	☐ Diet ☐ Medicine ☐ Other		☐ Yes ☐ No

In the past 2 years have special tests been done?	Are you aware of any recent readings?
☐ Yes, indicate type of test, date(s) and results ☐ No	☐ Yes, give readings ☐ No

Name and address of attending physician

Asthma or Chronic Bronchitis

Date of first attack (d,m,y)	Date of last attack (d,m,y)	How many attacks during the last	Has work time been lost within the past 2 years?
		a) 12 months _____ b) 24 months _____	☐ Yes, give dates and duration ☐ No

Treatment	Is breathing wheezy between attacks?	Do you now have symptoms?	Are you still under treatment?
☐ Medicine, give name(s) _____ ☐ Other, specify _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name and address of attending physician

Arthritis

Type	What joints were involved?
☐ Rheumatoid ☐ Osteoarthritis ☐ Other, specify	

Is there swelling or deformity?	Date problem began
☐ No ☐ Yes, give details	

In the past 2 years how frequent was the pain?	Was work time lost?	Duration
	☐ No ☐ Yes, give details	

Treatment	Are you still under treatment?
☐ Medicine, give name(s) _____ ☐ Other, specify _____	☐ Yes ☐ No, give date treatment last received

Name and address of attending physician

Alcohol Use

Present use	○ What is your present usual daily consumption (state kind and amount)?	How often does your consumption exceed this level?	How long have you been drinking to the extent described?
Former use	○ Have your drinking habits changed in the last 5 years? ☐ No ☐ Yes, when	State your former usual daily consumption (kind and amount)	
	How often did your consumption exceed this level?	How long were you drinking to the extent described?	
Treatment	○ Have you ever been treated or received advice for alcohol related problems? ☐ No ☐ Yes, state date for each occasion and name and address of individual or institution providing the treatment or advice		
	Are you a member of A.A. or a similar organization? ☐ No ☐ Yes, state date you joined	Have you had any relapses since joining? ☐ No ☐ Yes, give dates	

Nervous Disorder

Type	Date problem began (d,m,y)?	Date(s) of further occurrence(s) (d,m,y)
☐ Anxiety ☐ Depression ☐ Other, specify		

Duration of symptoms at each occurrence	Was time lost from work?
	☐ No ☐ Yes, give dates, duration and briefly describe symptoms

Treatment		Is condition still present?	Are you still under treatment?
☐ Medicine, give name(s) _____ ☐ Other, specify _____	☐ Hospitalization ☐ Psychiatrist consulted	☐ Yes ☐ No	☐ Yes ☐ No

Name and address of attending physician

The answers recorded above are given by me and are, to the best of my knowledge and belief, complete and true. I understand that, as contemplated by statute, any material misrepresentation or non-disclosure in the answers to the questions in the health questionnaires shall render coverage voidable by the insurer.

Employee Signature _____ Date Signed _____

Spouse Signature _____ Date Signed _____

CLEAR