

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: <ol style="list-style-type: none"> Complete, sign and date the Coverage Detail section. Retain a copy of the completed section for your files. Forward the original copy, along with the Medical & Lifestyle Questionnaire, to the employee. 	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 <i>(available for the deaf or hard of hearing)</i>
	Employee: <ol style="list-style-type: none"> Review, sign and date the Coverage Detail section. Complete Medical & Lifestyle Questionnaire and send both sections to Great-West Life. 	

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 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.)			
<input type="checkbox"/> BASIC COVERAGE			
<input type="checkbox"/> LATE APPLICANT (ELIGIBILITY PERIOD EXPIRED) No. of units or % of salary _____ Total amount _____			
<input type="checkbox"/> DEPENDENT COVERAGE			
<input type="checkbox"/> COVERAGE GREATER THAN THE NON-EVIDENCE MAXIMUM (NEM):			
	Current Amount (if applicable)	Non Evidence Maximum	New Total Amount Applied For
	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> OPTIONAL COVERAGE			
<input type="checkbox"/> EMPLOYEE: Current Amount (if applicable): \$ _____ New Total Amount Applied For: \$ _____		<input type="checkbox"/> 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 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 AVE., TORONTO, ONTARIO M5G 1R7, TELEPHONE 416.597.0590.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, 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.

MEDICAL & LIFESTYLE QUESTIONNAIRE

This application consists of two parts: *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.
<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 INFORMATION (if applicable). If you require more space, please complete additional form.

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

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 tumors 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 should 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".*

	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. ulcers , jaundice, chronic diarrhea, intestinal bleeding, pancreatitis, hepatitis, liver disease, or any other disease of the stomach, intestines, rectum or liver ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. asthma, bronchitis , shortness of breath, emphysema, tuberculosis or any other respiratory disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. abnormal urine, venereal disease, or any disease of the kidneys, bladder, prostate or reproductive organs or breasts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. **arthritis, back pain, fibromyalgia, systemic lupus erythematosus, 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, 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 _____
26. had any change in weight in the past year? (If "yes", indicate who) Yes No Yes No
Amount gained: _____ Amount lost: _____ Reason: _____

D E T A I L S	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 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 (located within or outside Canada) 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 personal information to be subject to disclosure to those authorized under applicable law within or outside Canada.

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 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 _____

Spouse Signature _____ Date Signed _____

Blood Pressure

Date first advised blood pressure elevated	Treatment <input type="checkbox"/> Diet <input type="checkbox"/> Medicine <input type="checkbox"/> Other	How long on treatment?	Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 2 years have special tests been done? <input type="checkbox"/> Yes, indicate type of test, date(s) and results <input type="checkbox"/> No		Are you aware of any recent readings? <input type="checkbox"/> Yes, give readings <input type="checkbox"/> 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 a) 12 months _____ b) 24 months _____	Has work time been lost within the past 2 years? <input type="checkbox"/> Yes, give dates and duration <input type="checkbox"/> No
Treatment <input type="checkbox"/> Medicine, give name(s) _____ <input type="checkbox"/> Other, specify _____		Is breathing wheezy between attacks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you now have symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name and address of attending physician			

Arthritis

Type <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Other, specify _____	What joints were involved?		
Is there swelling or deformity? <input type="checkbox"/> No <input type="checkbox"/> Yes, give details		Date problem began	
In the past 2 years how frequent was the pain?	Was work time lost? <input type="checkbox"/> No <input type="checkbox"/> Yes, give details	Duration	
Treatment <input type="checkbox"/> Medicine, give name(s) _____ <input type="checkbox"/> Other, specify _____	Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, state date you joined	Have you had any relapses since joining? <input type="checkbox"/> No <input type="checkbox"/> Yes, give dates	

Nervous Disorder

Type <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other, specify _____	Date problem began (d,m,y)?	Date(s) of further occurrence(s) (d,m,y)	
Duration of symptoms at each occurrence	Was time lost from work? <input type="checkbox"/> No <input type="checkbox"/> Yes, give dates, duration and briefly describe symptoms		
Treatment <input type="checkbox"/> Medicine, give name(s) _____ <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Hospitalization <input type="checkbox"/> Psychiatrist consulted	Is condition still present? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____