THE
Great-West Life
ASSURANCE COMPANY

Instructions:
*1. Please **PRINT**.*
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

Critical Illness Insurance - Confidential Physician's Report
Loss of Independent Existence

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL**

Part 1: Patient Authorization

	Policy No.
Name *(please print)*	Date of Birth *(day, month, year)*
Address *(number, street, city, province, postal code)*	Telephone no. *(including area code)* ( ) –

I hereby authorize the release to my insurer of any information **INCLUDING CONSULTATION REPORTS** with respect to this claim.

Patient's signature	Date *(day, month, year)*

Part 2: Physician's Report

1. Please provide a brief outline of the medical history leading to your patient's loss of independent existence.

2. When did your patient first consult you for the underlying medical condition that has led to this loss of independent existence?

   Date *(day, month, year)* ____________________

3. When did your patient first suffer symptoms of the medical condition that led to the loss of independent existence?

   Date *(day, month, year)* ____________________

4. Please provide the following:

   a) Which daily activities have affected your patient for a continuous period of at least 90 days - please check all/any that are applicable and provide details.

   ☐ Bathing ☐ Dressing ☐ Toileting ☐ Bladder and Bowel Continence ☐ Transferring ☐ Feeding

   ☐ Other Please provide details: ____________________

   b) Please provide the underlying cause(s) of this condition.

   c) Details of cognitive function impairment, if any.

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5. Does your patient have a reasonable chance of recovery? ______________________________

6. Are there any treatments that could improve the function of this individual? ______________________________

7. If available, please provide the names and addresses of other physicians consulted, inluding any hospitals attended by your patient for this condition.

Name of Physician or Hospital	**Address** *(number, street, city, province, postal code)*	**Date from** *(day, month, year)*	**Date to** *(day, month, year)*

8. Please provide results of all relevant investigations, if available, or include occupational therapy assessment and any cognitive testing results.

9. Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports.

Name of attending physician *(please print)*	Specialty	Telephone no. *(including area code)* ( ) —

Address *(number, street, city, province, postal code)*

Signature	Date *(day, month, year)*

Submit to: **The Great-West Life Assurance Company**
Critical Illness Claims Unit, S3
330 University Avenue
Toronto ON M5G 1R8
Toll Free 1.866.907.2395
Fax 416.552.6557

AUTHORIZATION AND DECLARATIONS:

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information".

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Patient Signature ____ Date Signed __________________________

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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage 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.

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