THE Great-West Life ASSURANCE COMPANY

OPTIONAL CRITICAL ILLNESS APPLICATION FOR NON-SMOKER RATE

For GWL Head Office Use Only

GWL Certificate Number

Please print clearly and complete this form, in INK and send to: The Great-West Life Assurance Company
Attn: Member Administration
PO Box 6000
Winnipeg MB R3C 3A5

1. General Enrollment Information

This section must be completed by the plan member.

Please print clearly in INK.

Plan number: _____

Plan sponsor: _____

Plan member name: _____
last name first name middle initial

Division number: _____ Plan member ID: _____

2. Plan Member Information

This section must be completed by the plan member.
Please print clearly in INK.

Plan member mailing address:

Street address: _____

City: _____ Province: _____ Postal Code: _____

3. Smoking Declaration

This section must be completed by the insured (plan member or spouse).

Name of insured: _____
last name first name middle initial

Date of birth: Month _____ Day _____ Year _____

i) Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form? ☐ Yes ☐ No

ii) In the past 2 years have you been treated for or had any indication of heart disease, stroke, cancer, or any respiratory disease or disorder? ☐ Yes ☐ No

4. Privacy

This section explains Great-West Life's commitment to privacy.

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.

5. Authorizations and Declarations

This section must be signed and dated in INK by the insured (plan member or spouse).

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

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, 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 the 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 Québec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Signature of insured: _____ **Date:** _____

Clear