

**Instructions** – Please print all answers clearly.

1. Plan Member completes sections 1, 2, and 3. Physician completes section 4.
2. This form must be completed in full to avoid a delay in assessing the application. Once we have all the required information and have completed our assessment, we will notify the plan member in writing.
3. Please retain a copy of this form for your records.
4. Fees for providing medical information are the plan member's responsibility and are not covered under the plan.

**Please send completed form to:** Medical and Dental Services  
The Great-West Life Assurance Company  
PO Box 6000  
Winnipeg, MB R3C 3A5  
Fax: 204-938-2820  
Email: [MedicalServices@gwl.ca](mailto:MedicalServices@gwl.ca)

**Questions?** Call Toll Free: 1-800-957-9777 Or  
Refer to your Great-West Life Employee Benefits Booklet  
For the deaf or hard of hearing:  
Toll Free: 1-800-990-6654

*As email is not a secure medium, any person with concerns about their medical information being intercepted by an unauthorized party is encouraged to submit their forms by other means.*

Section 1 – Plan Member Information				
Plan Number	Plan Member I.D. Number			
Last Name	First Name			
Address	City and Province	Postal Code		
Section 2 – Dependent Information				
Last Name	First Name			
Relationship to Plan Member	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-Law <input type="checkbox"/> Other: _____		
Residence of Dependent				
Plan Member's Home <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Group Home <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Hospital <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Other: _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time	
Dependent's Education				
Highest level of education attained: _____ Is the dependent currently attending an educational facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes":      Is the dependent attending full time? <input type="checkbox"/> Yes <input type="checkbox"/> No      Anticipated program completion date: (mm/dd/yy): _____				
Name of program and facility _____				
If "No":      When was the last day attended _____				
<b>Note: Please attach the most recent educational assessment and/or other assessments completed in the educational setting.</b>				
Dependent's Employment				
Has the dependent ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes" please provide the most recent date(s) and type(s) of employment.				
Period of employment (mm/dd/yy) to (mm/dd/yy)	Employer	Job Title	Average monthly income	Hours worked per week

**Section 3 – Authorizations and Declaration**

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Great-West Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare or dental care 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 located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

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](http://www.greatwestlife.com).

Plan Member Signature \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_

**Section 4 – Attending Physician's Statement**

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Date(s) condition(s) diagnosed: \_\_\_\_\_

**Functional Abilities**

Does the patient have impairments in PHYSICAL functioning?  Yes  No Are the impairments permanent?  Yes  No  N/A

If the impairments are not permanent, when are they expected to resolve or improve? \_\_\_\_\_

Does the patient have impairments in COGNITIVE functioning?  Yes  No Are the impairments permanent?  Yes  No  N/A

If the impairments are not permanent, when are they expected to resolve or improve? \_\_\_\_\_

Please describe the nature and severity of any cognitive impairments. **(Attach any recent cognitive assessment and/or neuropsychological report.)**

**Does the patient have impairments in any of the following areas?**

Sitting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Ambulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Lifting/Carrying	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Manual dexterity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____

**Please indicate whether your patient requires assistance managing any of the following, and if so, describe supports needed:**

Personal care/hygiene (bathing, dressing, toileting, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation (driving, taking bus, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment (taking medications, attending appts, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Routine/Schedule (creating and adhering to a schedule)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal finances (banking, paying bills, budgeting, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decision making (using judgement to make good decisions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home care (cooking, cleaning, grocery shopping, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Planning (ability to plan for the future)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Type(s) of supports required (*include physical supports, care supports, adaptive devices, etc*):

\_\_\_\_\_

Support is provided by (*include any agencies or people providing support*):

\_\_\_\_\_

**Treatment (*include medications, therapies, and other treatments; attach copies of recent investigations, assessments and consultations*)**

Date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Describe the current treatment plan (use a separate page if necessary)

\_\_\_\_\_

\_\_\_\_\_

List any other physicians / care providers involved in the patient's treatment (use a separate page if necessary)

Name	Specialty	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Prognosis:** \_\_\_\_\_  
 \_\_\_\_\_

Please provide any other comments you feel would assist us in understanding the patient's situation.

\_\_\_\_\_

\_\_\_\_\_

**I declare that the information in this section is true to the best of my knowledge.**

Physician's name (please print): \_\_\_\_\_ Specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_