Ambassador
Employee Application

The Ambassador plan is made available through Great-West Life. Group insurance coverage under the Ambassador plan is underwritten by Certain Lloyd's Underwriters (collectively, the "Insurer") and administered by MSH INTERNATIONAL (CANADA) LTD. (MSH INTERNATIONAL).

IMPORTANT INFORMATION

Please ensure that all questions on this form are answered in full. If any information is incomplete, processing of your application will be delayed, and coverage may not be in place on the date requested.

Complete an Ambassador Statement of Health Declaration, for yourself and for each family member who will be accompanying you on this foreign assignment. Your employer will advise you if the Statement of Health Declaration is not required.

The Insurer reserves the right to reconsider, apply surcharges or exclude coverage in countries it deems to be an extreme risk, a war risk or where sanctions are in effect. Such coverage reconsideration surcharges or exclusions may apply to coverage already in effect. Countries deemed to be an extreme risk, a war risk or where sanctions are in effect are subject to change. Advance notification of 15 days will be provided to your employer before any coverage reconsideration, surcharges or exclusions takes effect.

EMPLOYEE INFORMATION

☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.

Last name: _____

First name: _____

Usual first name: _____

Birth date: _____ ☐ Male ☐ Female
Month/Day/Year

What is your address during your foreign assignment? _____

_____

Country of current passport (home country): _____ Passport Number: _____

Are you currently eligible for any government sponsored health care coverage? ☐ Yes ☐ No

If yes, which province/country? _____ Registration Number: _____

Emergency contact during foreign assignment:

Name: _____ Relationship: _____

Address: _____

Telephone number: _____

If we require additional information to process your application, how can we contact you?

☐ by phone? Daytime phone #: _____

☐ by e-mail? E-mail address: _____

☐ by mail? Mailing address: _____

BENEFICIARY DESIGNATION

Full name: _____ Relationship: _____

You may change this beneficiary designation at any time upon written notice to MSH INTERNATIONAL through Great-West.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable" below.

I hereby make the above beneficiary designation:

☐ **Revocable,** I may change this beneficiary designation at any time.

DEPENDENT INFORMATION

If your home country is not Canada, Ambassador coverage is not available for your dependents who remain in the home country during your foreign assignment.

If your home country is Canada and you are covered under your employer's Great-West group plan, Ambassador coverage is available for your dependents. Coverage can be continued under your employer's Great-West group plan for your dependents remaining in Canada.

Do you require Ambassador coverage for your spouse and/or children? ☐ Yes ☐ No

If yes, please provide the following information for **each** person for whom coverage is required.

Coverage is required for the following date: _____

(Note: the effective date of coverage for a person is the later of the start date of the foreign assignment and the date medical evidence is approved by MSH INTERNATIONAL.)

Please complete an Ambassador **Statement of Health Declaration** for **each** dependent for whom coverage is being requested.

First name Last name	Relationship to employee (Spouse/Child)*	Date of birth	If covered by a government sponsored health care coverage, provide province/county and registration number

*If common law spouse, indicate length of cohabitation. _____

If child requiring coverage is 19 years of age or older, please provide the following information:

Child's full name: _____

Is he or she financially dependent on you or your spouse? ☐ Yes ☐ No

If no, please explain: _____

Is he or she residing with you or your spouse? ☐ Yes ☐ No

Is he or she married or living in a common-law relationship? ☐ Yes ☐ No

Is he or she in full-time attendance at a recognized school, college or university? ☐ Yes ☐ No

If yes, please provide the name and address of the school, college or university:

_____

_____

Duration of educational program (in full): From (mm/yy) _____ To (mm/yy) _____

If more than one dependent child is age 19 or older, please attach a separate page providing the above details for **each additional** dependent child.

TO BE COMPLETED BY YOUR EMPLOYER

Name of employer (full legal name): _____

Country of foreign assignment: _____ Foreign assignment start date: _____

What is the anticipated length of foreign assignment? _____

Foreign assignment occupation: _____

Details of job duties: _____

Number of hours worked per week: _____ Annual base salary (in Canadian currency): _____

Is this employee currently covered under a Great-West group plan for medical and/or dental? ☐ Yes ☐ No

If yes, Great-West group plan number(s) _____ Certificate # _____

PROTECTING YOUR PERSONAL INFORMATION

At MSH INTERNATIONAL we recognize and respect the importance of privacy. When you apply for a product or service, we establish a confidential file that contains your personal information. This file is kept in the offices of MSH INTERNATIONAL or an organization authorized by MSH INTERNATIONAL. You may exercise certain rights of access and rectification with respect to the information in your file by sending a request in writing to Great-West's address listed in this application. We limit access to personal information in your file to MSH INTERNATIONAL staff or persons authorized by MSH INTERNATIONAL who require it to perform their duties and to persons to whom you have granted access. In addition, as personal information may be collected, used, disclosed or kept in or outside Canada, it may be subject to disclosure under applicable Canadian or foreign law. Your personal information will be collected, used and disclosed to: (1) process this application and, if this application is approved, provide and administer the financial product(s) or service(s) applied for, (2) advise you of products and services to help you plan for financial security, (3) respond to, investigate and process claims, and (4) create and maintain records concerning our relationship.

AUTHORIZATION AND DECLARATION

I hereby apply for group insurance coverage underwritten by Certain Lloyd's Underwriters and administered by MSH INTERNATIONAL.

I authorize:

- My employer to deduct from my pay and remit to Great-West the plan member contributions required under the plan, if applicable;
- Any healthcare provider, my plan administrator, insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers to exchange personal information when necessary to determine my eligibility for coverage and to administer the plan.

In applying for coverage for dependents, I confirm that I am authorized to act on the dependent's behalf.

I agree that a photocopy or electronic copy of this Authorization and Declaration 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.

Signature of Employee _____ Date (dd/mm/yy) _____

Please return all pages of this form to your employer.

The plan administrator should forward a copy of this application to their Great-West representative and send the original to:

Ambassador - Coordinator

THE Great-West Life ASSURANCE COMPANY

Group Major Accounts Administration
Specialty Products Unit
PO Box 6000
Winnipeg MB R3C 3A5
Fax: 204.946.4594 E-mail: specialtyproductsunit@gwl.ca

Clear