THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY COVERAGE DETAIL

This application consists of two parts: *The Evidence of Insurability Coverage Detail* form and *Medical & Lifestyle Questionnaire.*

INSTRUCTIONS

Member:
Please complete in INK only (blue or black)

1. Fill in your name, address, date of birth and phone number.
2. Make your coverage election for yourself and/or your spouse on the coverage details page and sign and date at the bottom.
3. If you apply for more than the non-medical amount, complete the Medical & Lifestyle Questionnaire, put in a sealed envelope, attach to the Coverage Detail form.
4. **Return all forms to: I.A.T.S.E. Canada Health Plan Inc. J&D Benefits 228-8901 Woodbine Avenue Markham ON L3R 9Y4.**

Plan Administrator:

1. Provide plan name, division number, member ID and group policy number.
2. Review, sign and date (at bottom) Coverage details page.
3. Forward the original copy of the Coverage details page, along with the Medical questionnaire, in a sealed envelope to: Group Member Administration, Great-West Life PO Box 6000 Winnipeg MB R3C 3A5.

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
PO BOX 6000
WINNIPEG MB R3C 3A5
TEL 204.946.8554
TTY LINE 1.800.990.6654
(available for the deaf or hard of hearing)

Name of I.A.T.S.E. Local	Local No.	Group Policy No.	Division No.

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____

Member 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.

ID No. | Occupation

COVERAGE ELECTION SECTION

Optional Life is available in units of $5,000 up to a maximum of $500,000 per individual. **You may purchase up to $30,000 of Optional Life coverage for you and/or your spouse/partner without medical evidence** (must be applied for within 31 days of becoming eligible - contact your Plan Administrator for details)**.** Additional coverage above $30,000 is subject to medical evidence, or if you are applying after the 31 day eligibility period.

To apply for coverage:

1. Fill out the box below, complete the beneficiary designation, and sign and date the form.
2. If you wish to purchase more than $30,000 of coverage, or if you are applying after the 31 day eligibility period, the Medical & Lifestyle Questionnaire must also be completed.

Member: Smoker: ☐ Yes ☐ No
Gender ☐ Male ☐ Female Date of Birth _____/_____/_____ (mm/dd/yy)

Spouse: Smoker: ☐ Yes ☐ No
Gender ☐ Male ☐ Female Date of Birth _____/_____/_____ (mm/dd/yy)

Spouse Name (Last Name, First Name) _____

	Member	Spouse
☐ Existing Optional Life Coverage	$ _____	$ _____
☐ I elect the following coverage without medical evidence (Max $30,000)	$ _____	$ _____
If you are applying only for $30,000, you DO NOT need to complete the Medical & Lifestyles Questionnaire.		
☐ I elect the following amount, subject to medical evidence	$ _____	$ _____
Total Optional Life Coverage (Max $500,000 per individual)	$ _____	$ _____

Age Band	Males		Females	
	Non-Smoker	Smoker	Non-Smoker	Smoker
< 25	$0.05	$0.10	$0.03	$0.04
25 - 29	$0.05	$0.10	$0.03	$0.04
29 - 34	$0.05	$0.10	$0.03	$0.04
35 - 39	$0.05	$0.11	$0.04	$0.06
40 - 44	$0.07	$0.18	$0.06	$0.10

Age Band	Males		Females	
	Non-Smoker	Smoker	Non-Smoker	Smoker
45 - 49	$0.12	$0.33	$0.10	$0.18
50 - 54	$0.22	$0.56	$0.16	$0.29
55 - 59	$0.41	$0.95	$0.26	$0.44
60 - 64	$0.55	$1.27	$0.32	$0.53
65 - 69	$0.91	$2.10	$0.53	$0.88

Monthly rates are per $1,000 of coverage. Example, Male, non-smoker, age 52, purchasing $30,000 of coverage 30,000 / $1,000 x 0.22 = $6.60 monthly premium ($79.20 annually)

OPTIONAL LIFE BENEFICIARY DESIGNATION

_____
First Name Last Name

Relationship to member _____

The Beneficiary for the spousal coverage shall be the member if living, otherwise the estate. I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

NOTE: WHERE THE CIVIL CODE OF QUEBEC APPLIES, any designation of your spouse as beneficiary is irrevocable ("spouse" here includes any person recognized by law, in this context, as equivalent to your spouse), unless you stipulate the designation to be revocable, by checking the box marked revocable.

I hereby make the designation: ☐ Revocable ☐ Irrevocable

An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.

Plan Administrator's Signature: _____ Date: _____

Print Plan Administrator's Name: _____ Plan Administrator's Phone No.: _____

Member's Signature: _____ Date: _____

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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 0F 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

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. 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.

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THE Great-West Life ASSURANCE COMPANY

MEDICAL & LIFESTYLE QUESTIONNAIRE

This application consists of two forms:

The Evidence of Insurability Coverage Detail form and *Medical & Lifestyle Questionnaire.*

INSTRUCTIONS Member:

Please complete in INK only (blue or black)

1. Complete, sign and date the Medical & Lifestyle Questionnaire.
2. **Spousal information is only required if you are applying for dependant coverage.**
3. Attach (in a sealed envelope), the completed and signed Medical & Lifestyle Questionnaire to the original of the Coverage Detail form and send to your Plan Administrator.

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
PO BOX 6000
WINNIPEG MB R3C 3A5
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(available for the deaf or hard of hearing)

Name of I.A.T.S.E. Local	Local No.	Group Policy No.	Division No.

Employee Last Name	First Name	Middle Name	Gender
			☐ Male ☐ Female

Date of Birth: Month _____ Day _____ Year _____

SPOUSE/CHILD INFORMATION (if applicable). If you require more space, complete additional form.

	FIRST NAME LAST NAME	Gender	Date of Birth		
			Month	Day	Year
Spouse		☐ Male ☐ Female			

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: _____

Have you or your spouse:	**MEMBER** Yes	No	**SPOUSE** Yes	No
1. had any ailment, injury or illness in the past five years which caused the individual to be away from work or school for 10 days or more?	☐	☐	☐	☐
2. ever had high or low blood pressure, high cholesterol (and if so, advise if any treatment and most recent level), pain or tightness in the chest, or any heart disorder including disorders of the circulatory system?	☐	☐	☐	☐
3. ever had cancer, disorders of the blood, diabetes, hepatitis, liver disorder, kidney, respiratory or intestinal disorders?	☐	☐	☐	☐
4. ever had convulsions, loss of consciousness, fainting spells, severe headaches, nervous breakdown, mental illness, anxiety, depression, chronic fatigue syndrome, cerebral palsy, stroke, or any disorder of the nervous system?	☐	☐	☐	☐
5. ever had backache, rheumatic fever, rheumatism, arthritis, paralysis, fibromyalgia, or disorder of the muscles or bones, including joints, spine and skin?	☐	☐	☐	☐
6. had any disorder of eyes, ears, nose or throat?	☐	☐	☐	☐
7. had AIDS or other disorder of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	☐	☐	☐	☐
8. ever been in a hospital, sanitarium or other institution for treatment or observation?	☐	☐	☐	☐
9. any reason to believe you will require medical or surgical treatment during the next 12 months?	☐	☐	☐	☐
10. ever taken drugs, other than for medical purposes, been advised to drink less alcohol or received treatment for drug addiction or alcoholism?	☐	☐	☐	☐
11. ever had any serious illness or injury since childhood not mentioned above?	☐	☐	☐	☐
12. had X-rays, electrocardiograms, blood or other special tests, for other than regular medical checkups in the last five years? (indicate the test results below)	☐	☐	☐	☐
13. ever made a claim or received a pension, payments or compensation benefits for an accident or sickness?	☐	☐	☐	☐
14. ever had an application for insurance declined, postponed or modified in any way?	☐	☐	☐	☐
15. been involved in the operation of an aircraft, or participated in hazardous activities such as motorized racing, hang gliding, parachuting, or scuba diving? (If "yes", circle the appropriate activity)	☐	☐	☐	☐
16. smoked cigarettes in the past 12 months?	☐	☐	☐	☐
17. have your parents, brothers or sisters ever had cancer, diabetes, heart or kidney disease or any hereditary disorder? (If "yes", provide complete details)	☐	☐	☐	☐
18. had any change in weight in the past year? (If "yes", indicate who)	☐	☐	☐	☐

Amount gained: _____ Amount lost: _____ Reason: _____

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DETAILS

QUES. NO.	NAME	TEST, INJURY, ILLNESS, OPERATION OR COMPLICATION	DATE OF ONSET	DATE OF RECOVERY	FULL DETAILS (INCLUDING DOCTORS' NAMES AND ADDRESSES)

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 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 plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- 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 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.

Member Signature _____ Date Signed _____

Spouse Signature _____ Date Signed _____

Clear