

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

To be completed first by the plan member.

- ▶ Sections 1 & 2: Fill out your name, make your coverage election for yourself and/or your spouse, complete our optional life beneficiary designation and sign and date the bottom of the form.
- ▶ Sections 3 & 4: **Only** complete these sections if you wish to apply for insurance **above the \$30,000 or if you are applying more than 31 days after** you become eligible for benefits. Please put the medical questionnaire in a sealed envelope and attach it to the Coverage Detail form.
- ▶ Return all forms to: IATSE Canadian Health Plan Administration, J&D Benefits, 228-8901 Woodbine Avenue, Markham ON L3R 9Y4.

To be completed by the plan administrator.

- ▶ Sections 1 & 2: Provide plan name, division number, member ID and group policy number. Review the Coverage Detail, sign and date section 1.
- ▶ Mail the completed original documents to: Group Medical Underwriting, Great-West Life, PO Box 6000, Winnipeg MB R3C 3A5.

Section #1		Member's Information			
Name of I.A.T.S.E. Local		Policy No.		Division No.	Benefit Class
Title		Member Last Name		First Name	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____		Middle Initial		ID No.	
Date of Employment	Annual Earnings	Plan Administrator's Name	Plan Administrator's Phone No.	Plan Administrator's Email Address	
MMM/DD/YYYY			XXX-XXX-XXXX		
Plan Administrator's Authorization				Date Authorized	
<input type="checkbox"/> I hereby certify that the information on this Coverage Detail form is accurate.				MMM/DD/YYYY	

Section #2	Coverage Election Section	Completed by Member
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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 Optional Life Insurance:

1. Fill out the amount of Optional Life Insurance you already have under this plan as the Member Current Amount.
2. Fill out the amount of additional Optional Life Insurance you want to purchase as the Additional Amount Requested, complete the beneficiary designation, and sign and date the form.
3. If you wish to purchase more than \$30,000.00 of coverage, or if you are applying after the 31 day eligibility period, Medical & Lifestyle Questionnaire must be completed. (Sections 3 & 4)

Member Current Amount: \$	<input style="width: 90%;" type="text"/>	Spouse Current Amount: \$	<input style="width: 90%;" type="text"/>
Additional Amount Requested: \$	<input style="width: 90%;" type="text"/>	Additional Amount Requested: \$	<input style="width: 90%;" type="text"/>
Total Amount Applied for: \$	<input style="width: 90%;" type="text"/>	Total Amount Applied for: \$	<input style="width: 90%;" type="text"/>

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 \times 0.22 = \6.60 monthly premium (\$79.20 annually).

Optional Life Beneficiary Designation

Completed by Member

This section must be completed to designate a beneficiary for your Optional Life Insurance, if applicable. **The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed. Please print clearly, in INK.**

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

First Name	Last Name	Middle Initial	Percent allocated	Relationship to member

To be divided as follows: As per the percentage indicated above, or In equal shares to the survivor(s)

▶ 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 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 at any time

▶ 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.

Smoking Declaration

Completed by Member

Within the past 12 months have you smoked or used cigarettes, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts or tobacco, or nicotine in any other form?

	YES	NO
MEMBER	<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE	<input type="checkbox"/>	<input type="checkbox"/>

Plan Member's Signature

Signature	Date
	MMM/DD/YYYY

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Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

▶ Sections 3 & 4: Only complete these sections if you wish to apply for insurance **above the \$30,000 or if you are applying more than 31 days after** you become eligible for benefits. Please put the medical questionnaire in a sealed envelope and attach it to the Coverage Detail page.

Section #3 Member and Dependant Details Completed by the Member

Member Information				
Name of I.A.T.S.E. Local				Policy No.
<div style="border: 1px solid black; height: 20px;"></div>				
Title	Member Last Name	First Name	Middle Initial	Gender
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____				<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	Occupation	Job Duties		
MMM/DD/YYYY				
Home Mailing Address	Street	City	Province	Postal Code
<div style="border: 1px solid black; height: 20px;"></div>				
Email Address				
<div style="border: 1px solid black; border-radius: 10px; padding: 5px; background-color: #f0f0f0;"> NOTE: If you provide your email address, we may use it to communicate with you about this application. </div>				
Home Phone No.	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX XXX-XXXX	<input type="checkbox"/> Day <input type="checkbox"/> Evening	XXX XXX-XXXX	XXXX	<input type="checkbox"/> Day <input type="checkbox"/> Evening
Spouse Information (if applicable) - only required if you are applying for dependant coverage.				
Title	Spouse Last Name	First Name	Middle Initial	Gender
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> _____				<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	Occupation	Job Duties		
MMM/DD/YYYY				
Email Address				
<div style="border: 1px solid black; border-radius: 10px; padding: 5px; background-color: #f0f0f0;"> NOTE: If you provide your email address, we may use it to communicate with you about this application. </div>				
Home Phone No.	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX XXX-XXXX	<input type="checkbox"/> Day <input type="checkbox"/> Evening	XXX XXX-XXXX	XXXX	<input type="checkbox"/> Day <input type="checkbox"/> Evening

YOU SHOULD NOT TELL US ABOUT ANY GENETIC TESTING WHICH YOU MAY HAVE HAD DONE

Section #4

Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

MB = Member SP = Spouse

1. Do you now have or have you ever had: cancer, heart disease, diabetes, arthritis, any neurological, psychiatric, intestinal or respiratory disorders, or any other chronic medical condition(s)?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please describe medical condition, including the date of onset and duration.
2. Have you ever tested positive for hepatitis or HIV?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please describe which test, why you had it and when.
3. Have you ever had an MRI or CT scan?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide approximate year, describe for what reason(s) and the results.
4. Have you ever stayed overnight in a hospital?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide the approximate date that you left work, duration off work and medical condition.
6. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 5?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide date and describe the medical condition, if not already described above.
7. Have you ever had an application for disability insurance declined or modified?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide approximate year and describe for what reason(s).
8. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please describe the reason.
9. In the last 12 months have you been taking any prescription medication?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
10. Have you ever been advised to drink less alcohol by your physician, or used drugs (including marijuana) for non-medical reasons in the last 10 years?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide details of when, which product used, and frequency of use per week.
11. Do you drink alcohol?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide type of alcohol and quantity per week.
12. Within the past 12 months have you smoked or used cigarettes, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts, or tobacco, or nicotine in any other form?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide which product you use, how much/many per day.

Section #4 Personal Medical History and Lifestyle Information ...continued

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

MB = Member SP = Spouse

13. Have you gained or lost more than 10 pounds in the last 12 months?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please specify weight <u>loss or gain</u> , amount of change in weight, and reason.
14. Current height and weight: MEMBER: _____ m/cm or _____ feet/inches _____ kg or _____ pounds SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds		
15. Do you have a regular healthcare provider? If yes, please advise (in section to the right) Provider's name, address and date and reason of last appointment.	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	
16. Have you been referred to any medical specialists in the last 2 years?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please provide the name of specialist, type of specialty and medical reason for visit.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	Yes No MB <input type="checkbox"/> <input type="checkbox"/> SP <input type="checkbox"/> <input type="checkbox"/>	Please describe the type and frequency of the activity.
18. Please describe weekly exercise including type of activity, duration and frequency.		

Family History

19. For each applicant, do your parents, brothers or sisters, spouse or children suffer or have suffered from any of the following:

- Alzheimer's Disease
- Cancer
- Huntington's chorea
- Polycystic kidney disease
- Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Dementia
- Motor Neuron disease
- Stroke
- Diabetes
- Multiple Sclerosis
- and/or any other hereditary medical condition
- Heart Disease
- Parkinson's Disease

▶ **Member:** Yes No ▶ **Spouse:** Yes No

If yes, please complete the appropriate section below. Use extra paper if required.

Member (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Please provide any additional information that you feel is important:

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

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.

Authorization and Declarations

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., 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;
- Great-West Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Great-West Life to communicate with me about this application using the email address I have provided;
- 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 am actively at work on the date this application is signed;
- 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 _____
MMM/DD/YYYY

Spouse Signature _____ Date Signed _____
MMM/DD/YYYY

Additional Details

This page is to be used if you require **extra space to respond to a question.**
Provide the number of the question you are addressing.

MB = Member SP = Spouse

Question #	Details