THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR OVER-AGE DEPENDANT COVERAGE

INSTRUCTIONS - Please print all answers clearly

1. Plan Member completes sections 1, 2 and 4. Physician completes section 3.
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 not covered under your plan.**

Please send the completed form to:

Benefits of Film Plan Administrator
c/o J&D Benefits Inc.
#228-8901 Woodbine Avenue
Markham, ON L3R 9Y4

Questions? Call Toll Free: 1.800.218.7018
or email benefitsoffilm@jdbenefits.com

1. Plan Member Information

Please complete the following:

Plan Number	Plan Member I.D. Number	
Plan member last name	First name	
Address	City and province	Postal code

2. Dependant Information

Last name of dependant	First name
Relationship to plan member	Dependant date of birth (mm/dd/yy)

Is the disabled dependant a resident of your home 365 days a year? ☐ Yes ☐ No
If "No", please explain.

Has the dependant ever been employed? ☐ Yes ☐ No
If "Yes", please give most recent dates of employment and description of type of employment.

Date (mm/dd/yyyy)	Type of employment

Highest level of education attained _____
Is he/she currently attending an educational facility? ☐ Yes ☐ No
If "Yes", name of program/facility _____
If "No", when was the last day attended? _____
If your dependent has had an educational assessment completed in the past, please attach the most recent one to this form.

M6943-6/12

3. Attending Physician

Physician name (print) _____

Address _____
Number and Street | City or town | Province | Postal code

1. What is the clinical diagnosis, the nature and degree of this patient's condition? Please provide as much detail as possible and use a separate page if needed. Copies of specialist reports and test results are welcomed if relevant to the diagnosis.

_____

_____

_____

_____

2. When was the above condition diagnosed? (mm/dd/yy) _____
3. When was the patient last examined? (mm/dd/yy) _____
4. How does the patient's condition restrict their ability to engage in the activities of daily living?

_____

_____

5. What type of work can the individual perform?

_____

_____

6. Please confirm the date that this patient has been unable to work or attend school full-time due to their condition.

_____

_____

7. What is the prognosis?

_____

_____

8. Please describe the patient's current treatment regime.

_____

_____

9. Please list the patient's medications, route and dosage (use a new page if required).

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

10. Are there any additional remarks or observations you can provide?

_____

_____

_____

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

Physician's signature _____ Date (mm/dd/yy) _____

4. Authorizations and Declarations

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. 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.

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, 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. I certify that the information given is true, correct, and complete to the best of my knowledge.

Please sign and date here.

Plan member's signature _____ Date (mm/dd/yy) _____