

# **EVIDENCE OF INSURABILITY COVERAGE DETAIL**

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

Please complete in INK only (blue or black)

**INSTRUCTIONS** Plan Administrator: 1. Complete, sign and date the Coverage Detail section.

**Employee:** 

- 2. Retain a copy of the completed section for your files.
- Forward the original copy, along with the Medical & Lifestyle Questionnaire, to the employee.
- 1. Review, sign and date the Coverage Detail section.
- 2. Complete Medical & Lifestyle Questionnaire.
- Make a copy of both sections for your records and send the ORIGINALS to Great-West Life.

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)

Nam	ne of Group Policyholde	er (Employer)			Group Policy No.	Division No.		
□м	Ir. □ Ms. E	Employee Last Name	Firs	t Name	Middle Name	Gender		
□ M								
$\square$ M	liss 🗆					☐ Male ☐ Female		
	Date of Birth	Employee's Annual Earning	js –	ID No.	Class	Class		
Moi	nth Day Year	\$						
	DUDDO	SEE OF THIS ADDITION	TION (Make a	uvo vou only complete	the applicable acet	iono \		
_				ure you only complete	ine applicable seci	ions.)		
	•	ELIGIBILITY PERIOD EXPIRE rently being applied for	:טן:					
	· ·		Children					
	Basic Life							
	Healthcare *Dental		□ * Note:	Dontal rootrictions may apply	Pofor to your amployed	and let or contract		
	Short Term Disability		Note:	Dental restrictions may apply.	Refer to your employee t	DOOKIEL OF CONTRACT.		
	Long Term Disability							
	COVERAGE GREATE	R THAN THE NON-EVIDENC	E MAXIMUM (NE	EM):				
	0	Current	·	New Total Amount				
	Coverage	Amount		Applied for				
	Life Insurance	\$		\$				
	Long Term Disability	\$		\$				
	Short Term Disability	\$	_	\$				
	OPTIONAL LIFE INS		ODOLIOAL OD	FIONAL LIFE INCLIDANCE	OLULD ODTIONAL LIE	E INICHE ANICE		
	EMPLOYEE OPTIONA			FIONAL LIFE INSURANCE	CHILD OPTIONAL LIF			
	Existing Optional Life:	\$	Existing Option		Additional Amount Applied for: \$			
	Additional Amount App	lied for: \$						
	New Total Applied for:	\$	New Total Appl	ied for: \$	New Total Applied for:	\$		
	If plan is % of salary, st	tate percent applied for	_ If plan is an opt	ion or choice, state	_ If plan is an option or c	hoice, state		
ОРТ	TIONAL LIFE BENEFIC	CIARY DESIGNATION						
First	Name		Last Name		Relationship to	employee		
The	Beneficiary for the spo			living, otherwise the estate. I he	•			
and	designate the following	g as beneficiary(ies).						
NO1	TE: Where Quebec law	w applies and you have desig marked "Revocable", below.	nated your marrie	d spouse or civil union spouse	as beneficiary, the design	nation will be irrevocable		
l	•	peneficiary designation:						
l_		je this beneficiary at any time						
An ii	rrevocable beneficiary			en consent of the irrevocable be	neficiary. A revocable ber	neficiary designation can		
	-		*					

	OPTIONAL CRITICAL ILLNE	SS INSURANCE					
	New employees and their spo Maximum (NEM) amount for t			0 , ,			to the Non-Evidence
	**Medical questionnaire not	required if applying fo	r the NEM amount. Ov	erall maximum for optional	critical il	lness insuranc	e is \$250,000.
	EMPLOYEE OPTIONAL CRIT	ΓICALL ILLNESS INSUR	ANCE	SPOUSAL OPTIONAL CRI	TICAL II	LLNESS INSUI	RANCE
	Existing Optional     Critical Illness Amount:	\$		Existing Optional     Critical Illness Amount:	\$		_
	2. Amount Applied for:	\$		2. Amount Applied for:	\$		
	3. New Amount Applied for:	\$		3. New Amount Applied for			
	4. Amount Available Without Evidence:	\$		4. Amount Available Without Evidence:	\$		
	5. Amount Applied for With Medical Evidence:	\$	(3-4)	<ol><li>Amount Applied for With Medical Evidence:</li></ol>			(3-4)
Plar	n Administrator's Signature:					 _ Date:	
							mm/dd/yyyy
Prin	t Plan Administrator's Name: _			Plan Administra	tor's Ph	one No.:	
Emi	ployee's Signature:					Date:	
'''							mm/dd/yyyy

#### 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 <a href="https://www.greatwestlife.com">www.greatwestlife.com</a>.



# **MEDICAL & LIFESTYLE QUESTIONNAIRE**

This application consists of two forms:

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

Please complete in INK only (blue or black)

- INSTRUCTIONS Employee: 1. Complete, sign and date the Medical & Lifestyle Questionnaire. Spousal information is only required if you are applying for
  - dependant coverage. 3. Submit **ORIGINALS** of the Medical & Lifestyle Questionnaire and the Evidence of Insurability Coverage Detail section to Great-West Life.

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 Gr	roup Policyhol	der (Employer)							Group Pol	licy No.	Division	No.
☐ Mr.	☐ Ms.	Employee Last Name			First Na	me			Middle Na	ame	Gender	
☐ Mrs. ☐ Miss	□ Dr.										☐ Male	☐ Female
Date	e of Birth	Occupation:					Email Add	dress: NOTE	if you provi	ide your emai	l address we	e may use it to
Month	Day Year		Email Add							you about thi		
		Job Duties.										
Home Mailir	ng Address	(	Street				City		Province		Postal Co	ode
Home Phon	ne Number (	)				Work	Phone Nur	mber (				
Best time to	call 🗌 Day	☐ Evening				Best t	time to call	☐ Day	☐ Even	ing		
SPOUSE IN	NFORMATION	(if applicable).				'						
☐ Mr.	☐ Ms.	Spouse Last Name			First Na	me			Middle Na	ame	Gender	
☐ Mrs. ☐ Miss	□ Dr.										☐ Male	☐ Female
Date	e of Birth	Occupation:					Email Add					e may use it to
Month	Day Year	Job Duties:						comm	unicate with	you about thi	s Applicatio	n.
Home Phon	ne Number (	)				Work	Phone Nur	mber (	)			
	call 🗆 Day						time to call	_	□ Even			
CHILD INF	ORMATION (	f applicable). If you requ	uire mor	e space,	complete	additio	nal form.					
											ate of Birt	th
	FIRST N	AME		LAS	ST NAME			Gen	der	Month	Day	Year
Child (1)								☐ Male ☐	Female			
Child (2)								☐ Male ☐	Female			
Child (3)								☐ Male ☐	Female			
Personal M	edical History	and Lifestyle Informati	on								ı	
		ny "Yes" answers in the s		low. If ext	ra space i	is require	ed, please a	attach a sep	arate shee	et of paper a	nd provide	the number
	ion you are ad			=Spouse		hild(ren)	.,,,					
cancer, any ne respirate	heart disea eurological, p	or have you ever had: se, diabetes, arthritis, sychiatric, intestinal or or any other chronic	EE SP CH	Yes	No	Please	describe me	edical condit	ion, includi	ing the date	of onset a	nd duration.
	ast 12 months hotion medicatio	ave you been taking any n?	EE SP CH	Yes	No			ame of m			uration, a	ind medical
alcohol incuding	3. Have you ever been advised to drink less alcohol by your physician, or used drugs, incuding marijuana, for non-medicinal reasons in the last 10 years?  Yes  EE  SP  CH  □					If Yes, please provide details of when, which product used and frequency of use per week.						

Personal Medical History and Lifestyle Informati	ion (con	<u>'t)</u>		
4. Have you ever stayed overnight in a hospital?	EE SP CH	Yes	No	Please provide approximate year, duration of stay and medical diagnosis.
Have you ever tested positive for hepatitis or HIV?	EE SP CH	Yes	No	Please describe which test, why you had it and when.
6. Have you ever had an MRI or CT scan?	EE SP CH	Yes	No	Please provide approximate year, describe for what reason(s) and the results.
7. Have you ever had an application for disability or life insurance declined or modified?	EE SP CH	Yes	No	Please provide approximate year and describe for what reason(s).
Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?		Yes	No	Please provide the approximate date that you left work, duration off work and medical condition.
9. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 8?		Yes	No	Please provide date and describe the medical condition, if not already described above.
10. Have you gained or lost more than 10 pounds in the last 12 months?	EE SP CH	Yes	No 	Please provide amount of weight loss or gain and reason.
11. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	EE SP CH	Yes	No 	Please describe the reason.
12. Do you have a regular family physician? If yes, please advise (in section to the right) Physician's name, address and date and reason of last appointment.	EE SP CH	Yes	No	
13. Have you been referred to any medical specialists in the last 2 years?	EE SP CH	Yes	No	Please provide the name of specialist, type of specialty and medical reason for visit.
14. Current height and weight:  EMPLOYEE: m/cm or				kg or pounds
SPOUSE: m/cm or	feet/	inches		kg or pounds
15. 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?	EE SP CH	Yes	No	Please provide which product you use, how much/many per day.
16. Do you drink alcohol?	EE SP CH	Yes	No	Please provide type of alcohol and quantity per week.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	EE	Yes	No	Please describe the type and frequency of the activity.

18. Please describe weekly exercise including type of activity, duration and frequency.

# **Family History**

huntington's chorea, polycystic k	idney dise oouse: $\square$	ase, diab <b>Yes</b> $\square$	etes, mental i No Childre	illness, substar •n: □ <b>Yes</b> □	or have suffered from any of the following: cancer, heart disease nce abuse or any chronic and/or hereditary medical condition.  No
	T T		1		1 Cu.
Employee (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness
.,	-				
Spouse	1	Age	Age at death	Approximate	
(Family Member/Relationship):	Gender	if living	if deceased	age at onset	Illness
	1		1		
Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness
( ann,			1. 4000	dgo at miner	
AUTHORIZATION AND DECLARATI	ONS				
I authorize:					
Great-West Life, any healthcare of government benefits or other	benefits p	rograms,	other organiza	ations, or servi	companies or reinsurance companies, the MIB Inc., administrators ce providers working with Great-West Life to exchange persona up benefits plan:
<ul> <li>Great-West Life, any healthcare of government benefits or other information, when necessary to of</li> </ul>	benefits pletermine n	orograms, ny insurab	other organiza	ttions, or servioninister the grou	ce providers working with Great-West Life to exchange persona
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mm/dd/yyyy