HBPA GROUP MEDICAL/DENTAL/LIFE INSURANCE – SUMMARY

Carrier: Canada Life
Insured Plan Administrator: Canada Life
Group Insurance Plan No.: 169290

BENEFITS SUMMARY

Life Insurance: - $30,000 coverage to age 70, reduces 50% to age 75
- $10,000 for each dependent

Accidental Death & Dismemberment: $30,000 coverage to age 70, reduces 50% to age 75

Extended Health Care:

- 100% Semi-private hospital
- 80% coverage for all benefits under Extended Health Care including prescription drugs, private duty nursing, ambulance, service and supplies, paramedical benefits, deluxe out-of-county coverage, eye exams.

Dental Care:

- 2020 Fee Guide (for general practitioners) 80% coverage for basic preventative care and maintenance including fillings, extractions, cleanings, x-rays, anesthetic, scaling, polishing, fluoride treatment
- 50% coverage for purchase of dentures
- $1,500 maximum per person per year

PLEASE SEE BENEFIT BOOKLET FOR DETAILED COVERAGE INFORMATION

CLAIM SUBMISSION

3 in 1 Drug Card Program

The 3 in 1 Drug Card program allows you to submit your Health and Dental claims directly to Canada Life through your Pharmacist's or Dental office's on-line computer system. This means less money paid out-of-pocket when claiming because Canada Life will pay your Pharmacist or Dental office directly.

Note, paper-based Health claims, for example, Paramedical services, will still need to be paid out-of-pocket and mailed to the following address:

Health Claims
London Benefit Payment Office
255 Dufferin Ave
London, Ontario N6A 4K1

If the cost of any proposed dental treatment is expected to exceed $500, it is always suggested that an estimate be submitted, before the treatment begin to the following address:

Dental Claims
London Benefit Payment Office
255 Dufferin Ave
London, Ontario N6A 4K1

MONTHLY COST (INCLUDING HST)

Period: **July 2021 – June 2022**

	SINGLE	COUPLE	FAMILY
Subsidized by HBPA:			
Class A (Hot walker, Groom, Exercise Rider, Asst. Trainer)	$90.88	$165.11	$207.27
Class A/K (Hot walker, Exercise Rider, Asst. Trainer over age 75)	$81.79	$154.53	$198.64
Class B (Owner, Trainer)	$109.86	$199.68	$250.68
Class B/K (Owner, Trainer over age 75)	$98.15	$185.44	$238.37
Not Subsidized by HBPA:			
Class C (Associate members, Tradesmen, Jockeys, Other)	$240.04	$445.27	$560.35
Class C/K (Associate members, Tradesmen, Jockeys, Other over age 75)	$210.56	$404.65	$519.73

Please note that all premium payments must be made with the pre-authorized withdrawal process and are withdrawn monthly on the 3rd of every month.

However, if your payment does not go through during the month, you will be notified in writing and be charged double the next month. If this transaction fails a second consecutive month, we will understand that you wish to cancel your coverage with Great West Life. Once terminated from the plan, you will have the possibility to re-enroll as a new applicant.

It is your responsibility to advise us of any address or banking information changes.

Contact Information:

For questions on **payments, enrolments and changes**, please contact Lesley Barker at lbarker@hbpa.on.ca or 416-747-5252 ext. 24.

APPLICATION FOR HBPA OF ONTARIO
GROUP MEDICAL/DENTAL/LIFE INSURANCE

Group Name: **Horseman's Benevolent & Protective Association** Group Number: **169290**

Name of Applicant: _____

If applying for a HBPA subsidy complete this section:
I apply for and certify that I am entitled to a subsidy from HBPA as I am a Licensed _____, AGCO license #_____for this year. I recognize that it is my responsibility to advise the HBPA of a change in my licensing status.

Pre-authorized monthly cost to member $ _____ (from Summary sheet).

Please complete, sign and date the following forms and attach it to this application:

1. Canada Life Benefits Enrolment Form
2. Canada Life Evidence of Insurability
3. Direct Payment Service Authorization Form including a void cheque

Please return this application and the above-mentioned forms along with a copy of your current AGCO license to:

Lesley Barker
Benefits Administrator & Executive Assistant
HBPA Administrative Offices
420 - 135 Queen's Plate Drive
Toronto, Ontario
M9W 6V1

Telephone: 1-866-779-3067

I hereby designate the following as my revocable beneficiary, in the event of my death.

Name:_____ Age:_____ Relationship:_____

I hereby apply for the above coverages under the HBPA Medical/Dental/Life Insurance plan. I understand that the insurer Canada Life will determine my eligibility for this insurance based on the Evidence of Insurability Form, submitted concurrently.

I also understand that dental coverage does not commence until 6 months following Canada Life's approval of this application.

Date:_____ Signature:_____

THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE

For GWL Head Office Use Only
GWL Certificate Number

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 7 are to be completed by the plan member.

1. Plan Sponsor Section

This section is to be completed by the plan administrator.

Plan number: _____ Division number: _____ Benefit class: _____

Plan sponsor: _____

Plan member ID: _____ Cost centre (if applicable): _____

Eligible date of employment: Month _____ Day _____ Year _____

Effective date of coverage: Month _____ Day _____ Year _____

Occupation: _____ Earnings: $ _____ per ☐ year ☐ month ☐ week ☐ hour

Plan member province of residence: _____ Plan member province of employment: _____

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly in INK.

Plan member name (print): _____
last name first name middle initial

Gender: ☐ Male ☐ Female Date of birth: Month _____ Day _____ Year _____

Plan member mailing address:

Street address: _____

City: _____ Province: _____ Postal code: _____

Do you have a spouse (married, common-law or civil union spouse)? ☐ Yes ☐ No

Do you have dependant children, including full time students or disabled adults? ☐ Yes ☐ No

How many dependants in total, including spouse? _____

3. Refusal of Benefits

This section is to be completed by the plan member.

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **I decline** to participate in:

Healthcare for ☐ myself and my dependants ☐ my dependants only

Dentalcare for ☐ myself and my dependants ☐ my dependants only

Spousal insurer's name: _____ Plan number: _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependants may be required to provide proof of insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. Beneficiary Designation

This section must be completed to designate a beneficiary for your life benefits, 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.

Beneficiary's name(s)			Percent allocated	Relationship to plan member
last name _____	first name _____	middle initial _____	_____	_____
last name _____	first name _____	middle initial _____	_____	_____
last name _____	first name _____	middle initial _____	_____	_____

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

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

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**

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to his/her tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Great-West Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. **Before designating a trust, you should seek legal advice.**

For All Other Applicants - If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes. **Before designating a trust, you should seek legal advice.**

CONTINUE ON REVERSE SIDE

M6191-10/13

To be completed by the plan administrator

Plan number: _____ Plan member name: _____ Plan member ID: _____

5. Dependant Information

This section is to be completed by the plan member.
Complete this section if the plan includes health and/or dental coverage and you have not refused such coverage for your dependants in section 3.
If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Spouse Information

last name | first name | middle initial

Date of birth (month/day/year) _____

Gender Male ☐ Female ☐

What group benefits coverage does your spouse have through his/her employer?

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Dependant Information

last name	first name	middle initial	Date of birth month/day/year	Gender Male	Gender Female	Full time student Yes	Disabled dependant Yes
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

6. Privacy

This section explains Great-West Life's commitment to privacy.

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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage 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.

7. Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

I hereby apply for coverage under the group benefits plan issued by Great-West Life.

I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information".

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- 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 or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of the Authorizations and Declarations 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.

Plan member signature: _____ **Date:** _____

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
Please complete in INK only (blue or black)

Plan Administrator:
1. Complete, sign and date the Coverage Detail section.
2. Retain a copy of the completed section for your files.
3. Forward the original copy, along with the Medical & Lifestyle Questionnaire, to the employee.

Employee:
1. Review, sign and date the Coverage Detail section.
2. Complete Medical & Lifestyle Questionnaire.
3. 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)

Name of Group Policyholder (Employer)	Group Policy No.	Division No.

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____	Employee Last Name	First Name	Middle Name	Gender ☐ Male ☐ Female

Date of Birth			Employee's Annual Earnings	ID No.	Class
Month	Day	Year	$		

PURPOSE OF THIS APPLICATION (Make sure you only complete the applicable sections.)

☐ **LATE APPLICANT (ELIGIBILITY PERIOD EXPIRED):**
Check coverage currently being applied for

	Employee	Spouse	Children
Basic Life	☐	☐	☐
Healthcare	☐	☐	☐
*Dental	☐	☐	☐
Short Term Disability	☐		
Long Term Disability	☐		

***Note:** *Dental restrictions may apply. Refer to your employee booklet or contract.*

☐ **COVERAGE GREATER THAN THE NON-EVIDENCE MAXIMUM (NEM):**

Coverage	Current Amount	New Total Amount Applied for
Life Insurance	$_____	$_____
Long Term Disability	$_____	$_____
Short Term Disability	$_____	$_____

☐ **Supplemental Life:** ☐ **Basic Life:**

Existing Amount: $_____
New Amount Applied for: $_____
New Total Amount: $_____

☐ **OPTIONAL LIFE INSURANCE**

EMPLOYEE OPTIONAL LIFE INSURANCE	SPOUSAL OPTIONAL LIFE INSURANCE	CHILD OPTIONAL LIFE INSURANCE
Existing Optional Life: $_____	Existing Optional Life: $_____	Existing Optional Life Amount: $_____
Additional Amount Applied for: $_____	Additional Amount Applied for: $_____	Additional Amount Applied for: $_____
New Total Applied for: $_____	New Total Applied for: $_____	New Total Applied for: $_____
If plan is % of salary, state percent applied for_____	If plan is an option or choice, state _____	If plan is an option or choice, state _____

OPTIONAL LIFE BENEFICIARY DESIGNATION

First Name _____ Last Name _____ Relationship to employee _____

The Beneficiary for the spousal or child coverage shall be the employee 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.

M5995-4/15

☐ **OPTIONAL FLEX BENEFITS**

EMPLOYEE OPTIONAL LONG TERM DISABILITY INSURANCE

	$ Amount
Current % of Monthly Benefit: _____ %	_____
New Option: _____ % of monthly earnings	_____
Total Monthly Benefit Amount:	_____

EMPLOYEE OPTIONAL SHORT TERM DISABILITY INSURANCE

	$ Amount
Current % Weekly Benefit: _____ %	_____
New Option: _____ % of weekly earnings	_____
Total Weekly Benefit Amount:	_____

☐ **OPTIONAL CRITICAL ILLNESS INSURANCE**

New employees and their spouses may elect, without evidence, within 31 days of eligibility, Optional Critical Illness Insurance up to the Non-Evidence Maximum (NEM) amount for their group plan. The NEM must be confirmed by plan administrator. (Step 4 below).

****Medical questionnaire not required if applying for the NEM amount.** Overall maximum for optional critical illness insurance is $250,000.

EMPLOYEE OPTIONAL CRITICALL ILLNESS INSURANCE

1. Existing Optional Critical Illness Amount: $ _____
2. Amount Applied for: $ _____
3. New Amount Applied for: $ _____ (1+2)
4. **Amount Available Without Evidence:** **$** _____
5. Amount Applied for With Medical Evidence: $ _____ (3-4)

SPOUSAL OPTIONAL CRITICAL ILLNESS INSURANCE

1. Existing Optional Critical Illness Amount: $ _____
2. Amount Applied for: $ _____
3. New Amount Applied for: $ _____ (1+2)
4. **Amount Available Without Evidence:** **$** _____
5. Amount Applied for With Medical Evidence: $ _____ (3-4)

☐ **SOLACE INSURANCE**

☐ Employee ☐ Spouse

Plan Administrator's Signature: _____ Date: _____ mm/dd/yyyy

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

Employee'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 www.greatwestlife.com.

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 Employee:
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. 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 Group Policyholder (Employer)	Group Policy No.	Division No.

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____	Employee Last Name	First Name	Middle Name	Gender ☐ Male ☐ Female

Date of Birth: Month	Day	Year	Occupation: _____ Job Duties: _____	Email Address: **NOTE:** if you provide your email address we may use it to communicate with you about this Application.

Home Mailing Address	Street	City	Province	Postal Code

Home Phone Number (_____) _____ Best time to call ☐ Day ☐ Evening	Work Phone Number (_____) _____ Best time to call ☐ Day ☐ Evening

SPOUSE INFORMATION (if applicable).

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____	Spouse Last Name	First Name	Middle Name	Gender ☐ Male ☐ Female

Date of Birth: Month	Day	Year	Occupation: _____ Job Duties: _____	Email Address: **NOTE:** if you provide your email address we may use it to communicate with you about this Application.

Home Phone Number (_____) _____ Best time to call ☐ Day ☐ Evening	Work Phone Number (_____) _____ Best time to call ☐ Day ☐ Evening

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

	FIRST NAME **LAST NAME**	Gender	Date of Birth: Month	Day	Year
Child (1)		☐ Male ☐ Female			
Child (2)		☐ Male ☐ Female			
Child (3)		☐ Male ☐ Female			

Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. If extra space is required, please attach a separate sheet of paper and provide the number of the question you are addressing. EE=Employee SP=Spouse CH=Child(ren)

		Yes	No	
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)?	EE	☐	☐	Please describe medical condition, including the date of onset and duration.
	SP	☐	☐	
	CH	☐	☐	
2. In the last 12 months have you been taking any prescription medication?	EE	☐	☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
	SP	☐	☐	
	CH	☐	☐	
3. Have you ever been advised to drink less alcohol by your physician or used drugs for non-medical reasons in the last 10 years?	EE	☐	☐	If Yes, please provide details and when.
	SP	☐	☐	
	CH	☐	☐	

Personal Medical History and Lifestyle Information (con't)

4. Have you ever stayed overnight in a hospital?		Yes / No	Please provide approximate year, duration of stay and medical diagnosis.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
5. Have you ever tested positive for hepatitis or HIV?		Yes / No	Please describe which test, why you had it and when.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
6. Have you ever had an MRI or CT scan?		Yes / No	Please provide approximate year, describe for what reason(s) and the results.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
7. Have you ever had an application for disability or life insurance declined or modified?		Yes / No	Please provide approximate year and describe for what reason(s).
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
8. 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.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
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.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
10. Have you gained or lost more than 10 pounds in the last 12 months?		Yes / No	Please provide amount of weight loss or gain and reason.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
11. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?		Yes / No	Please describe the reason.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
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.		Yes / No	
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
13. Have you been referred to any medical specialists in the last 2 years?		Yes / No	Please provide the name of specialist, type of specialty and medical reason for visit.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	

14. Current height and weight:

EMPLOYEE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds

SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds

15. Within the past 12 months have you smoked or used cigarettes, marijuana, hashish, cigars, pipe, cigarillos, chewing tobacco, nicotine patch and/or gum, betel nuts, or tobacco, or nicotine in any other form?		Yes / No	Please provide which product you use, how much/many per day.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
16. Do you drink alcohol?		Yes / No	Please provide type of alcohol and quantity per week.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	
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	Please describe the type and frequency of the activity.
	EE	☐ ☐	
	SP	☐ ☐	
	CH	☐ ☐	

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: cancer, heart disease, huntington's chorea, polycystic kidney disease, diabetes, mental illness, substance abuse or any chronic and/or hereditary medical condition?
Employee: ☐ **Yes** ☐ **No** **Spouse:** ☐ **Yes** ☐ **No** **Children:** ☐ **Yes** ☐ **No**
If yes, please complete the appropriate section below. Use extra paper if required.

Employee (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness

Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness

Please provide any additional information that you feel is important:

_____

_____

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.

Employee Signature _____ Date Signed _____
mm/dd/yyyy

Spouse Signature _____ Date Signed _____
mm/dd/yyyy

THE Great-West Life ASSURANCE COMPANY

Personal Pre-Authorized Debit ("PAD") Agreement
Bank Account Change Form

To change the bank account used for your pre-authorized debit arrangements complete this form and return it to The Great-West Life Assurance Company. Please detach the *Plan Members Copy* and keep it for your records.

Plan Member: _____ Plan Number(s): _____

Plan Member ID: _____

Account Information

Name and address of Financial Institution: _____

Transit Number: _____ Bank Code: _____ Account Number: _____

Important Note: Please provide this PAD agreement and an unsigned blank cheque marked "VOID" to Great-West's Group Major Accounts Administration. The completed PAD agreement must be received by Group Major Accounts Administration at least 14 days prior to the first withdrawal day.

Terms and Conditions of this Personal PAD Agreement

• **Authorization**	**Note:** References in this form to "this PAD agreement" include later amendments to it. I, the account holder, authorize The Great-West Life Assurance Company (Great-West) and my financial institution named above to withdraw monthly, on the 3rd day of each month or the next business day, from my account any payments that I have agreed to make under the plan(s) listed above (the "Plan(s)"), and/or as otherwise specified to be made in this PAD agreement as though I had personally signed a cheque. I understand that changes to the Plan(s), including as applicable, to amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the monthly amount withdrawn or to be withdrawn from my account. **Accordingly, I authorize such increases or decreases, waiving any pre-notification requirement with respect to them.** I consent to Great-West's collection, use, retention and exchange of personal information concerning me, in my capacity as account holder and only as required for purposes relating to this PAD agreement. I agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.
• **Signatures**	I certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.
• **Account changes**	I will notify Great-West if my financial institution, branch or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the next withdrawal date. Great-West may, but is not obligated to, rely on verbal instructions from me to amend this authorization.
• **Confirming withdrawals**	I agree to regularly review my account information and if I question or disagree with the amount withdrawn or any account changes, I will notify Great-West in writing within 90 days of the withdrawal or account changes; otherwise, I agree that the withdrawal or account changes will be considered to have been properly made. Great-West's contact information for questions related to these withdrawals is: The Great-West Life Assurance Company, Group Major Accounts Administration - D102, PO Box 6000, Stn. Main, Winnipeg, MB R3C 3A5, Telephone 204.946.8094.
• **Non-sufficient funds (NSF) information**	If there is not enough money in my account to cover the total monthly amount due ("due" as an amount owing, or as an amount otherwise specified to be withdrawn under this PAD agreement), I authorize Great-West to immediately make a second attempt to withdraw the amount due (which may be greater than the amount due at the first attempt). If the second attempt is also returned NSF (or if Great-West decides, in its sole discretion, not to make the second attempt), I understand that pre-authorized payments may be suspended, and possibly cancelled by Great-West. I understand that I am responsible for any NSF charge(s).
• **Assignment**	**I hereby waive any requirement of prior written notice to me by Great-West of the assignment by Great-West of this PAD agreement.**
• **Cancellation**	This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by me to Great-West or by Great-West to me. To obtain a sample cancellation form, or for more information on your right to cancel this PAD agreement, contact your financial institution or visit www.cdnpay.ca. To obtain more information on your PAD agreement, contact Great-West at Group Major Accounts Administration, Telephone 204.946.8094. I agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Great-West, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Great-West, in its sole discretion, may require a new written PAD agreement if this PAD agreement is cancelled for any reason.
• **Recourse**	You have certain recourse rights if any debit does not comply with this PAD agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain information on your recourse rights, contact your financial institution or visit **www.cdnpay.ca**.

Signed at: _____ on _____
City Province Month Day Year

Name of **account holder**

X _____

Name of **other joint account holder(s)**

X _____

Signature of account holder

X _____

Signature of other joint account holder(s), if required for account

X _____

M6940(GMA)-2/10

Plan Members Copy

Please detach this page and keep a copy for your records.

Personal Pre-Authorized Debit ("PAD") Agreement
Bank Account Change Form

Terms and Conditions of this Personal PAD Agreement	
• **Authorization**	**Note:** References in this form to "this PAD agreement" include later amendments to it. I, the account holder, authorize The Great-West Life Assurance Company (Great-West) and my financial institution named above to withdraw monthly, on the 3rd day of each month or the next business day, from my account any payments that I have agreed to make under the plan(s) listed above (the "Plan(s)"), and/or as otherwise specified to be made in this PAD agreement as though I had personally signed a cheque. I understand that changes to the Plan(s), including as applicable, to amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the monthly amount withdrawn or to be withdrawn from my account. **Accordingly, I authorize such increases or decreases, waiving any pre-notification requirement with respect to them.** I consent to Great-West's collection, use, retention and exchange of personal information concerning me, in my capacity as account holder and only as required for purposes relating to this PAD agreement. I agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.
• **Signatures**	I certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.
• **Account changes**	I will notify Great-West if my financial institution, branch or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the next withdrawal date. Great-West may, but is not obligated to, rely on verbal instructions from me to amend this authorization.
• **Confirming withdrawals**	I agree to regularly review my account information and if I question or disagree with the amount withdrawn or any account changes, I will notify Great-West in writing within 90 days of the withdrawal or account changes; otherwise, I agree that the withdrawal or account changes will be considered to have been properly made. Great-West's contact information for questions related to these withdrawals is: The Great-West Life Assurance Company, Group Major Accounts Administration - D102, PO Box 6000, Stn. Main, Winnipeg, MB R3C 3A5, Telephone 204.946.8094.
• **Non-sufficient funds (NSF) information**	If there is not enough money in my account to cover the total monthly amount due ("due" as an amount owing, or as an amount otherwise specified to be withdrawn under this PAD agreement), I authorize Great-West to immediately make a second attempt to withdraw the amount due (which may be greater than the amount due at the first attempt). If the second attempt is also returned NSF (or if Great-West decides, in its sole discretion, not to make the second attempt), I understand that pre-authorized payments may be suspended, and possibly cancelled by Great-West. I understand that I am responsible for any NSF charge(s).
• **Assignment**	**I hereby waive any requirement of prior written notice to me by Great-West of the assignment by Great-West of this PAD agreement.**
• **Cancellation**	This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by me to Great-West or by Great-West to me. To obtain a sample cancellation form, or for more information on your right to cancel this PAD agreement, contact your financial institution or visit www.cdnpay.ca. To obtain more information on your PAD agreement, contact Great-West at Group Major Accounts Administration, Telephone 204.946.8094. I agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Great-West, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Great-West, in its sole discretion, may require a new written PAD agreement if this PAD agreement is cancelled for any reason.
• **Recourse**	You have certain recourse rights if any debit does not comply with this PAD agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain information on your recourse rights, contact your financial institution or visit **www.cdnpay.ca**.