THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY COVERAGE DETAIL

Great-West Life your Benefits Solutions People

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

INSTRUCTIONS

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 and send both sections to Great-West Life.

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
P.O. BOX 6000
WINNIPEG, MANITOBA R3C 3A5
TELEPHONE (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.
CAPREIT LIMITED PARTNERSHIP	**158496 / 158497**	

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

Employee's Annual Earnings: $ | ID No. | Occupation

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 INSURANCE:**
Current Amount: $_____
New Total Amount Applied for: $_____

☐ **OTHER COVERAGE (PLEASE SPECIFY INCLUDING AMOUNT)**
_____
_____

☐ **OPTIONAL LIFE INSURANCE**

EMPLOYEE OPTIONAL LIFE INSURANCE
Existing Optional Life Amount: $ _____
New Total Amount Applied for: $ _____
If plan is % of salary, state percent applied for _____

SPOUSAL OPTIONAL LIFE INSURANCE
Existing Optional Life Amount: $ _____
New Total Amount Applied for: $ _____
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 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.

☐ **OPTIONAL FLEX BENEFITS**

EMPLOYEE OPTIONAL LONG TERM DISABILITY INSURANCE
Current % of Monthly Benefit: _____ %
New Option: _____ % of monthly earnings
Total Monthly Benefit Amount: $ _____

EMPLOYEE OPTIONAL SHORT TERM DISABILITY INSURANCE
Currently Weekly Benefit: $ _____
New Option: _____ % of weekly earnings
Total Weekly Benefit Amount: $ _____

Plan Administrator's Signature: _____ Date: _____

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

Employee's Signature: _____ Date: _____

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NOTICE ABOUT MEDICAL INFORMATION BUREAU

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 MEDICAL INFORMATION BUREAU, 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 AVE., TORONTO, ONTARIO M5G 1R7, TELEPHONE (416) 597-0590.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life (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. We use the personal information to determine your insurability and to administer the group benefits plan.

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THE Great-West Life ASSURANCE COMPANY

MEDICAL & LIFESTYLE QUESTIONNAIRE

Great-West Life your Benefits Solutions People

This application consists of two forms:

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

INSTRUCTIONS Employee:
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.

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GROUP MEDICAL UNDERWRITING
P.O. BOX 6000
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TELEPHONE (204) 946-8554
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Name of Group Policyholder (Employer)	Group Policy No.	Division No.
CAPREIT LIMITED PARTNERSHIP	**158496 / 158497**	

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____ | Employee Last Name | First Name | Middle Name

Date of Birth: Month _____ Day _____ Year _____ Employee Height? _____ ☐ m/cm ☐ ft/in Employee Weight? _____ ☐ kg ☐ lb

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

	FIRST NAME LAST NAME	Sex	Date of Birth Month	Day	Year	Height	Weight
Spouse		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb
Child (1)		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb
Child (2)		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb
Child (3)		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb

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, your spouse, or your children:	**EMPLOYEE** Yes	No	**SPOUSE** Yes	No	**CHILDREN** 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, 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. 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 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 Medical Information Bureau;
- 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 _____

Spouse Signature _____ Date Signed _____

Clear