THE Great-West Life ASSURANCE COMPANY

SOLACE

APPLICATION FOR COVERAGE

Great-West Life your Benefits Solutions People

INSTRUCTIONS **Complete this form and send to:** THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
P.O. BOX 6000
WINNIPEG, MANITOBA R3C 3A5
TELEPHONE (204) 946-8554

Please print

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

☐ 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.

ID No.	Class	Occupation

SPOUSE INFORMATION (if applicable).

FIRST NAME	LAST NAME	Sex	Date of Birth Month	Day	Year	Height	Weight
		☐ Male ☐ Female				☐ m/cm ☐ ft./in.	☐ kg ☐ lb.

If you answered "Yes" to any question in 2 through 9 below, you are not eligible for Solace coverage.	**Employee Yes**	**Employee No**	**Spouse Yes**	**Spouse No**
1. Have you used tobacco in any form or a smoking cessation product in the last 12 months?	☐	☐	☐	☐
2. Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment or care for:				
• AIDS, a positive HIV test or AIDS related disease	☐	☐	☐	☐
• Alcohol or drug abuse within the past 5 years	☐	☐	☐	☐
• Alzheimer's Disease or Parkinson's Disease	☐	☐	☐	☐
• Cancer, tumour or other malignancy, leukemia, Hodgkin's Disease	☐	☐	☐	☐
• Cerebral Palsy, Muscular Dystrophy, Down's Syndrome, developmental or mental retardation	☐	☐	☐	☐
• Cystic Fibrosis	☐	☐	☐	☐
• Diabetes	☐	☐	☐	☐
• Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congenital heart disorder	☐	☐	☐	☐
• Hemophilia	☐	☐	☐	☐
• Hepatitis C or Chronic Hepatitis B or Hepatitis B carrier state	☐	☐	☐	☐
• Huntington's Chorea	☐	☐	☐	☐
• Kidney Disease other than kidney stones	☐	☐	☐	☐
• Motor Neuron Disease including Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	☐	☐	☐	☐
• Multiple Sclerosis	☐	☐	☐	☐
• Permanent Paralysis	☐	☐	☐	☐
• Organ transplant	☐	☐	☐	☐
• Stroke or Transient Ischemic Attack (TIA)	☐	☐	☐	☐
• Systemic Lupus Erythematosus (SLE)	☐	☐	☐	☐
3. In the last 5 years, have you had optic neuritis, or unexplained visual disturbance, unexplained loss of balance or unexplained weakness of the extremities?	☐	☐	☐	☐

(continued)

	Employee		Spouse	
	Yes	No	Yes	No
4. Is your weight greater than the maximum weight listed in the chart below? **(ages 18 and up only)**	☐	☐	☐	☐

HEIGHT	MAXIMUM WEIGHT		HEIGHT	MAXIMUM WEIGHT	
	Males	Females		Males	Females
Feet / Inches	Lbs.	Lbs.	Centimeters	Kg.	Kg.
4’10”	188	173	150	89	80
4’11”	193	177	152	90	82
5’0”	198	182	154	91	84
5’1”	203	187	156	92	86
5’2”	208	192	158	94	87
5’3”	213	198	160	96	89
5’4”	219	203	162	98	91
5’5”	226	208	164	101	93
5’6”	231	213	166	102	95
5’7”	238	219	168	105	97
5’8”	244	224	170	107	99
5’9”	250	229	172	109	101
5’10”	258	237	174	111	103
5’11”	264	245	176	114	105
6’0”	271	254	178	117	108
6’1”	277	263	180	119	111
6’2”	285	274	182	121	114
6’3”	292	283	184	124	117
6’4”	302	294	186	126	121
6’5”	310	303	188	130	125
6’6”	320	314	190	131	129

5. Have **2 or more** of your immediate family members (parents, sisters, brothers) been diagnosed with cancer prior to age 60?	☐	☐	☐	☐
6. Have **2 or more** of your immediate family members (parents, sisters, brothers) been diagnosed with cardiovascular disease (heart attack, angina, stroke) prior to age 60?	☐	☐	☐	☐
7. Have **2 or more** of your immediate family members (parents, sisters, brothers) been diagnosed with multiple sclerosis prior to age 60?	☐	☐	☐	☐
8. Have **1 or more** of your immediate family members (parents, sisters, brothers) been diagnosed with any one of the following diseases prior to age 60?	☐	☐	☐	☐
• Huntington’s Chorea	☐	☐	☐	☐
• Motor Neuron Disease including Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)	☐	☐	☐	☐
• Parkinson’s Disease	☐	☐	☐	☐
• Polycystic Kidney Disease	☐	☐	☐	☐
9. During the last two (2) years have you:				
a) Had an abnormal result of any of the following: EKG, stress EKG, echocardiogram, mammogram, Pap smear (if 2 subsequent Pap smears have been normal, disregard), PSA, sigmoidoscopy, colonoscopy, biopsy?	☐	☐	☐	☐
b) Had an abnormal result of any of the following: X-ray, CAT scan or MRI (other than for the common cold, osteoarthritis, fractures or injuries)?	☐	☐	☐	☐
c) Had elevated blood pressure or cholesterol, which has not been controlled with medical treatment?	☐	☐	☐	☐
d) Had any anemia (**except** females under the age of 50 with iron deficiency anemia that has been treated and is under control), unexplained blood loss or unintentional weight loss of more than 10 lbs?	☐	☐	☐	☐

Provide the name and address of your usual medical advisor:

	Employee	Spouse
Name of Doctor or Hospital	_____	_____
Address or Doctor or Hospital	_____	_____
	_____	_____

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.

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 date Great-West Life makes a decision 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 Québec 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 _____

NOTICE ABOUT MEDICAL INFORMATION BUREAU

Important Notice

YOUR PERSONAL INFORMATION WILL BE TREATED AS CONFIDENTIAL. GREAT-WEST LIFE OR ITS REINSURERS 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.

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. 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 insurabilty and to administer the group benefits plan.

IF YOU WISH TO SEE THE INFORMATION IN YOUR BUREAU FILE OR HAVE IT CORRECTED, PLEASE CONTACT THE BUREAU. THE BUREAU'S INFORMATION OFFICE IS AT SUITE 501, 330 UNIVERSITY AVE., TORONTO, ONTARIO M5G 1R7, TELEPHONE (416) 597-0590.