Evidence of Insurability

Group Policy No. 20570/No. 20571

Coverage Detail and Medical and Lifestyle Questionnaire

Group Medical Underwriting
P.O. Box 6000
Winnipeg, Manitoba R3C 3A5
Phone: 204-946-8554

1. This form can be filled out on-screen by tabbing to each field, or you may print the blank form and complete by hand.
2. Once completed, the printed original copy must be signed, dated and sent to The Great-West Life Assurance Company, Group Medical Underwriting, P.O. Box 6000, Winnipeg, Manitoba, R3C 3A5.
3. You must retain a copy for your own records.
4. You and your Ministry will be notified from Great-West Life if your application is approved.
5. You will be notified if your application is denied.

Name of Employing Government Ministry			
☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ __________	Employee Last Name	First Name	Middle Name
Home Mailing Address	Street	City	Province
Postal Code	Date of Birth (Y/M/D)	Home Phone No. ( )	Business Phone No. ( ) Ext.
Employee's Annual Earnings: $		Employee ID:	
Employee Height:	☐ m/cm ☐ ft/in	Employee Weight: __________	☐ kg ☐ lb

Complete this section if you are requesting an increase in Core Life Insurance:

Present Amount of Insurance:	Core:	☐ 1x annual salary	☐ 2.5x annual salary
Requested Amount of Insurance:	Core:	☐ 1x annual salary	☐ 2.5x annual salary

Complete this section if you are enrolling in the Enhanced Life Insurance or requesting an increase in Insurance:

Note: you must have a minimum of Core 2.5x to apply for the Enhanced coverage.

Present Amount of Insurance:	Enhanced	☐ 1x annual salary	☐ 2x annual salary	☐ 3x annual salary	☐ 4x annual salary
Requested Amount of Insurance:	Enhanced	☐ 1x annual salary	☐ 2x annual salary	☐ 3x annual salary	☐ 4x annual salary

Yes	No	If answer is YES to any of the questions, give full details on page 2: (if more space is needed, attach another sheet, sign and date)
		Have you:
☐	☐	1. had any ailment, injury or illness in the past five years which caused you to be away from work 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 any 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 sports such as motorized racing, hang gliding, parachuting, skin or scuba diving? (If yes, circle the appropriate sport)
☐	☐	16. smoked cigarettes in the past 12 months?
☐	☐	17. had any change in weight in the past year?
		Amount gained: __________ Amount lost: __________ Reason: __________

A benefits program for Government of Alberta union employees

DETAILS	Ques No.	Test, Injury, Illness, Operation or Complication	Date of		Full Details (including Doctors' Names and Addresses)
			Onset	Recovery	

Authorization and Declarations

I authorize:

- Great-West, any healthcare provider, my plan administrator, other insurance companies, the Medical Information Bureau, other organizations, or benefit service providers working with Great-West to exchange information, when necessary to determine my insurability and to administer the group benefit plan;
- Great-West 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;
- 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 statements and answers on the form between the date this form is signed and the date Great-West makes a decision must be reported to Great-West. 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, I am not insurable for all or part of that benefit.

Date Signed: ______________________________ Signature of Employee: ____

Important Notice
About Medical Information Bureau

Your personal information will be treated as confidential. Great-West 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 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. The Bureau's information office is at 330 University Avenue, Toronto, Ontario, M5G 1R7,
Telephone 416-597-0590.

Protecting Your Personal Information

At Great-West we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West or the offices of an organization authorized by Great-West. We limit access to information in your file to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to provide you with financial services and to administer the group benefit plan.