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 member.

Member:
1. Review, sign and date the Coverage Detail section.
2. Complete Medical & Lifestyle Questionnaire and send both sections to Great-West Life.
3. Please complete and sign the Personal Pre-Authorized Debit ("PAD") Agreement on page 5 and attach a "VOID" cheque for the account to be used for your monthly debits.
4. Please detach page 7 and keep a copy of the Personal Pre-Authorized Debit ("PAD") Agreement for your records.

THE GREAT-WEST LIFE ASSURANCE COMPANY
Group Major Accounts Administration - D102
P.O. Box 6000, Stn. Main
WINNIPEG, MANITOBA R3C 3A5
TELEPHONE 204.946.8094
TTY LINE 1.800.990.6654
(available for the deaf or hard of hearing)

Name of Group Policyholder (Employer)	Group Policy No.	Division No.
STANDARDBRED CANADA	**43431**	

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

Member 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. | Occupation (describe duties)

PURPOSE OF THIS APPLICATION

Amount of Optional Group Term Insurance currently in force:

Member $ _____ Spouse $ _____

Check the life insurance amount you are applying for:

Member			Spouse		
	☐ $25,000	☐ $150,000		☐ $25,000	☐ $150,000
	☐ $50,000	☐ $175,000		☐ $50,000	☐ $175,000
	☐ $75,000	☐ $200,000		☐ $75,000	☐ $200,000
	☐ $100,000	☐ $225,000		☐ $100,000	☐ $225,000
	☐ $125,000	☐ $250,000		☐ $125,000	☐ $250,000

Total Insurance:

Member $ _____ Spouse $ _____

Amount Paid with application:

Member $ _____ Spouse $ _____

OPTIONAL LIFE BENEFICIARY DESIGNATION

First Name Last Name

Relationship to member _____

The Beneficiary for the spousal or child coverage shall be the member if living, otherwise the estate.

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.

Plan Administrator's Signature: _____ Date: _____

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

Member'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.

Next

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 Member:

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 Major Accounts Administration - D102
P.O. Box 6000, Stn.Main
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.
STANDARDBRED CANADA	**43431**	

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

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

SPOUSE 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

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 or your spouse:	**MEMBER** Yes	No	**SPOUSE** 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, high cholesterol (and if so, advise if any treatment and most recent level), 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. have your parents, brothers or sisters ever had cancer, diabetes, heart or kidney disease or any hereditary disorder? (If "yes", provide complete details)	☐	☐	☐	☐
18. had any change in weight in the past year?	☐	☐	☐	☐

Amount gained: _____ Amount lost: _____ Reason: _____

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DETAILS

QUES. NO.	NAME	TEST, INJURY, ILLNESS, OPERATION OR COMPLICATION	DATE OF		FULL DETAILS (INCLUDING DOCTORS' NAMES AND ADDRESSES)
			ONSET	RECOVERY	

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.

Member Signature _____ Date Signed _____

Spouse Signature _____ Date Signed _____

THE Great-West Life ASSURANCE COMPANY

Personal Pre-Authorized Debit ("PAD") Agreement

Plan Member: _____ Plan Number(s): 43431

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 Department. The completed PAD agreement must be received by Group Major Accounts Administration Department 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 _____

Clear

Plan Members Copy

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

Personal Pre-Authorized Debit ("PAD") Agreement

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.
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• **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**.