THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY COVERAGE DETAIL

Doctors Manitoba

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

INSTRUCTIONS Member:

Please complete in INK only (blue or black)

1. Complete, sign and date the Coverage Detail form.
2. Complete Medical & Lifestyle Questionnaire, place in a sealed envelope and send both forms to:

Doctors Manitoba
20 Desjardins Drive
Winnipeg MB R3X 0E8

Plan Administrator: 1. Review, sign and date the Coverage Detail form.

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	Group Policy No.	SIN
DOCTORS MANITOBA	**335330**	

☐ 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.

Email Address

Do you currently have any Basic and/or Optional Life insurance under this group insurance plan? ☐ Yes ☐ No

If Optional, provide amount: $ _____

I apply for insurance under the Policy issued by The Great-West Life Assurance Company to Doctors Manitoba, subject to the terms and provisions thereof. (Do not include any benefits already in force under this Plan.)

Member:					**Annual Premium**	**Total Insurance Amount**
Term Life Insurance	☐ Yes	Units of $6,500	No. of units _____	X Unit Rate _____ =	$ _____	$ _____
Dependent:						
Basic Life **Plan A** (Spouse & Children)	☐ Yes ☐ No				$ _____	$ _____
Optional **Plan B** (Spouse Only)	☐ Yes	Units of $6,500	No of units _____	X Unit Rate _____ =	$ _____	$ _____
				Total A + B _____ =	$ _____	

Total Annual Premium for all benefits applied for = $ _____

Prorated Premium due = $ _____ (Total annual premium) X _____ (No. of months to Jan. 1 (excluding present month)) + 12 = $ _____

Cheque payable to Doctors Manitoba enclosed for _____

MEMBER LIFE BENEFICIARY DESIGNATION

First Name | Last Name | Relationship to Plan Member

SPOUSE LIFE BENEFICIARY DESIGNATION

First Name | Last Name | Relationship to Spouse

Contingent beneficiary - If the above beneficiary dies before me, the death benefit set out in the plan is to be paid to:

☐ My estate, or

Name of contingent beneficiary | Relationship to Plan member

Plan Administrator's Signature: _____ Date: _____

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

Member's Signature: _____ Date: _____

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Trustee – recommended for any beneficiary under age 18, or any beneficiary who may not be able to give a valid discharge.

DO NOT USE THIS SECTION IF THERE IS A WRITTEN TRUST AGREEMENT.

I appoint _____

Relationship to life to be insured _____

as trustee to receive, in trust, benefits under the Great-West Life group policy referred to above. This appointment applies to benefits payable to any beneficiary designated under this contract who, at the time benefits are payable, is a minor or lacks legal capacity to give a valid discharge according to the laws of the beneficiary's domicile. Payment of benefits to the trustee discharges Great-West Life to the extent of the payment.

I authorize the trustee in his or her sole discretion to use the benefits for the education or maintenance of the beneficiary and to exercise any right of the beneficiary under the group policy. The trustee may, in addition to the investments authorized for trustees, invest in any product of, or offered by, Great-West Life or its affiliated financial institutions. The trust for any beneficiary will terminate, once that beneficiary is both of age of majority and has legal capacity to give a valid discharge, and I direct the trustee to deliver at that time to the beneficiary, the assets held in trust for that beneficiary. I or my personal representative (in Quebec: my tutor, curator, liquidator or mandatary in the event of incapacity) may by writing appoint a new trustee to replace a former trustee.

☐ No trustee desired

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.*

Doctors Manitoba

INSTRUCTIONS Member:

Please complete in INK only (blue or black)

Please print

1. Complete, sign and date the Medical & Lifestyle Questionnaire.
2. **Spousal information is only required if you are applying for dependant coverage.**
3. Place in a sealed envelope and send along with the Coverage Detail form to"
   Doctors Manitoba
   20 Desjardins Drive
   Winnipeg MB R3X 0E8

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
PO BOX 6000
WINNIPEG MB R3C 3A5
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Name of Group Policyholder (Employer)	Group Policy No.	SIN
DOCTORS MANITOBA	**335330**	

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

Date of Birth: Month _____ Day _____ Year _____

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

	FIRST NAME	**LAST NAME**	Gender	Date of Birth		
				Month	Day	Year
Spouse			☐ 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.

		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)?	MB SP	☐ ☐	☐ ☐	Please describe medical condition, including the date of onset and duration.
2. In the last 12 months have you been taking any prescription medication?	MB SP	☐ ☐	☐ ☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
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?	MB SP	☐ ☐	☐ ☐	If Yes, please provide details and when.
4. Have you ever stayed overnight in a hospital?	MB SP	☐ ☐	☐ ☐	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever tested positive for hepatitis or HIV?	MB SP	☐ ☐	☐ ☐	Please describe which test, why you had it and when.
6. Have you ever had an MRI or CT scan?	MB SP	☐ ☐	☐ ☐	Please provide approximate year, describe for what reason(s) and the results.
7. Have you ever had an application for disability or life insurance declined or modified?	MB SP	☐ ☐	☐ ☐	Please provide approximate year and describe for what reason(s).
8. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	MB SP	☐ ☐	☐ ☐	Please provide the approximate date that you left work, duration off work and medical condition.

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Personal Medical History and Lifestyle Information (con't)

9. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 8?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please provide date and describe the medical condition, if not already described above.
10. Have you gained or lost more than 10 pounds in the last 12 months?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please provide amount of weight loss or gain and reason.
11. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please describe the reason.
12. Do you have a regular family physician?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please provide their name and clinic address, as well as the approximate date and reason for last visit.
13. Have you been referred to any medical specialists in the last 2 years?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please provide the name of specialist, type of specialty and medical reason for visit.

14. Current height and weight:

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

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

15. Have you used tobacco in the last year?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please provide number of cigarettes per day.
16. Do you drink alcohol?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please provide type of alcohol and quantity per week.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	MB ☐ Yes ☐ No SP ☐ Yes ☐ No	Please describe the type and frequency of the activity.

18. Please describe weekly exercise including type of activity, duration and frequency.

Member	Spouse

Family History

19. For each applicant, if 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, please complete the section below. Please use extra paper if required.

Member (Family Member/Relationship):	Gender	Approx. age at onset	Age if living	Age of death if deceased	Illness

Spouse (Family Member/Relationship):	Gender	Approx. age at onset	Age if living	Age of death if deceased	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;
- 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.

Member Signature _____ Date Signed _____

Spouse Signature _____ Date Signed _____

Clear