THE Great-West Life ASSURANCE COMPANY

DOCTORS MANITOBA
APPLICATION TO EXERCISE FUTURE INSURANCE OPTION

Name of member

Last name | Given name

Date of birth (day, month, year)

Mailing Address

Number and Street

City | Province | Postal code

Residence telephone number | Business telephone number

Amount of units applied for (units of $7,000)

Number of units		Premium per unit		Total amount
	x	$	=	$ 0.00

Are you disabled and on claim or satisfying a waiting period? ☐ Yes ☐ No

Privacy

Protecting Your Personal Information

This section explains Great-West Life's commitment to privacy.

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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage 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.

Clear

THE
Great-West Life
ASSURANCE COMPANY

Authorization and declarations

This section must be signed and dated in INK by the plan member.

I hereby apply for the changes in coverage under the group benefits plan issued by Great-West Life.

I have read and understand and agree with the contents of the section on this form entitled “Protecting Your Personal Information”.

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

I understand any material misrepresentation may render the coverage voidable at the option of the Insurer. As a member of Doctors Manitoba, I understand and agree that, if issued, the Optional Amount will become effective on the date the application is received by Doctors Manitoba.

For Quebec applicants: I request that this form be in English.

Je demande que ce formulaire me soit remis en anglais.

Member signature: _____ **Date:** _____

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