THE Great-West Life ASSURANCE COMPANY

Critical Illness Claimant's Statement

Please print in ink. Incomplete forms will be returned.

Claimant name	Plan number	Division number	Plan member I.D. number

Address *(number, street, city, province, postal code)*

Date of birth *(dd/mm/yyyy)*	Sex	Phone number *(including area code)*
	☐ Male ☐ Female	( ) –

Claim and Related Details

1. Please describe the nature and extent of your critical illness: _____

_____

_____

On what date was your condition diagnosed or surgery performed? Date *(dd/mm/yyyy)* _____

2. On what date did symptoms start? Date *(dd/mm/yyyy)* _____

Please describe these symptoms: _____

_____

3. On what date did you first consult a medical practitioner in connection with your illness? Date *(dd/mm/yyyy)* _____

Please indicate the name and address of the physician seen:

Name Phone number *(including area code)*

( ) –

_____

Address *(number, street, city, province, postal code)*

_____

4. Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates:

_____

_____

5. Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No

If yes, please give details, including dates: _____

_____

_____

Medical Consultations

1. Please provide the name and address of your personal physician:

Name

Phone number *(including area code)*

( ) –

Address *(number, street, city, province, postal code)*

2. Please provide details of any physicians who have been consulted in connection with your illness:

Name	**Address** *(number, street, city, province, postal code)*	**Phone number** *(including area code)*	**Dates seen** *(dd/mm/yyyy)*
		( ) –	
		( ) –	
		( ) –	

3. If you have been treated at a hospital or similar institution, please supply the following information:

Name of hospital	**City or town**	**Date of admission** *(dd/mm/yyyy)*	**Date of discharge** *(dd/mm/yyyy)*

4. What other treatment have you received and are you currently receiving for your condition? (e.g., medications, therapy)

Type of treatment	**Institution**	**Prescribing physician**	**Dates** *(dd/mm/yyyy)*

General

1. Has any blood relative suffered from a similar or related condition? ☐ Yes ☐ No If yes, please indicate:

Relationship	**Nature of illness**	**Age at which illness was first diagnosed**

2. Are you insured for benefits related to this condition from another company? ☐ Yes ☐ No If yes, please indicate:

Name of insurer	**Type of benefit**	**Amount of benefit insured**	**Has a claim been submitted?**
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

3. Do you smoke or use tobacco products?

☐ Yes If yes, please indicate amount per day: _____ How long have you used tobacco? _____

☐ No If no, did you previously use tobacco products? ☐ Yes ☐ No

On what date did you quit? *(dd/mm/yyyy)* _____

4. Please provide any further information that might be helpful in support of your claim:

_____

_____

_____

Authorization and Declarations:

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life to exchange personal information, when necessary for the purpose of assessing my claim, and administering the group benefits plan;
- Great-West Life to release information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Great-West Life at any time for the purpose of auditing the assessment of the claims;
- 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.

Except for audit purposes, this authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this claim form and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

Print name _____ Signature _____

Date _____ Phone number _____

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 insurability and to administer the group benefits plan.

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 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 Ave.
Toronto ON M5G 1R7
Phone: 416.597.0590

The Great-West Life Assurance Company
Critical Illness Unit
330 University Ave.
Toronto ON M5G 1R8
Toll Free: 1.866.907.2395
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