THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY

Coverage Detail

Ontario Principals' Council | Benefits

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

Member

- Sections 1-2: To be completed, signed and dated by the Member, including completion of the smoking declaration.
- Sections 3-4: To be completed by the Member/spouse. Retain a copy of all pages for your files. Send to: Ontario Principals' Council.

Ontario Principals' Council

- Sections 1-3: To be reviewed and amended where necessary. Send the application to: Group Medical Underwriting, Great-West Life.

Clear Print

Section #1 Member's Information

Name of Group Policyholder	Policy No.	Cert. / OPC Member No.
ONTARIO PRINCIPALS' COUNCIL	175360 (LTD) 175361 (Optional Coverage)	

Member Last Name	First Name	Middle Initial

Annual Earnings	School Board

Is the Member currently actively at work? ☐ Yes ☐ No

If no, please indicate reason and Expected Return to Work Date. MMM/DD/YYYY

☐ Maternity/Paternity ☐ On Claim / Personal LOA / Other

Section #2 Reason for Application

Section #2 (A) Long Term Disability

☐ Not currently covered for LTD or Late Applicant (after 60 day open enrolment)

☐ Wanting to change LTD Options **Current Coverage** _____ **Desired Coverage** _____

Section #2 (B) Term Life Insurance

Member

☐ New Applicant (applying after 60 day open enrolment or applying for coverage over $100,000)

☐ Increasing Life Coverage. **Current Coverage** _____ **Desired Coverage** _____

Spouse

☐ New Applicant (applying after 60 day open enrolment or applying for coverage over $100,000)

☐ Increasing Life Coverage **Current Coverage** _____ **Desired Coverage** _____

Dependent

☐ New Applicant (applying after 60 day open enrolment)

☐ Increasing Life Coverage. **Current Coverage** _____ **Desired Coverage** _____

Smoking Declaration

Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form?

	YES	NO
MEMBER	☐	☐
SPOUSE	☐	☐

Plan Member's Signature

Signature	Date
	MMM/DD/YYYY

M5995(175360)-3/19

THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY

Applicant Information

Section #3 Member and Dependant Details *Completed by the Member*

Member Information

Name of Group Policyholder: **ONTARIO PRINCIPALS' COUNCIL**

Policy No.: **175360 (LTD)** **175361 (Optional Coverage)**

Member Last Name	First Name	Middle Initial	Gender
			☐ Male ☐ Undisclosed ☐ Female ☐ Other

Date of Birth	Occupation	Job Duties
MMM/DD/YYYY		

Home Mailing Address	Street	City	Province	Postal Code

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX-XXX-XXXX	☐ Day ☐ Evening	XXX-XXX-XXXX	XXXX	☐ Day ☐ Evening

Spouse Information (if applicable) - *only required if you are applying for dependant coverage.*

Spouse Last Name	First Name	Middle Initial	Gender
			☐ Male ☐ Undisclosed ☐ Female ☐ Other

Date of Birth	Occupation	Job Duties
MMM/DD/YYYY		

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX-XXX-XXXX	☐ Day ☐ Evening	XXX-XXX-XXXX	XXXX	☐ Day ☐ Evening

Child Information (if applicable) - *only required if you are applying for dependant coverage.*

	Child Last Name	Child First Name	Gender	Date of Birth
Child (1)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY
Child (2)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY
Child (3)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY
Child (4)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY

YOUR APPLICATION CANNOT BE PROCESSED IF ALL APPROPRIATE QUESTIONS ARE NOT ANSWERED

YOU SHOULD NOT TELL US ABOUT ANY GENETIC TEST WHICH YOU MAY HAVE HAD DONE. YOU MUST HOWEVER, TELL US IF YOU ARE HAVING TREATMENT FOR, OR EXPERIENCING SYMPTOMS OF A GENETIC CONDITION.

Section #4 Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 6 - Additional Details at the end of this document and provide the number of the question.**

MB = Member **SP** = Spouse **CH** = Child(ren)

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)?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe medical condition, including the date of onset and duration.
2. Have you ever tested positive for hepatitis or HIV?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe which test, why you had it and when.
3. Have you ever had an MRI or CT scan?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year, describe for what reason(s) and the results.
4. Have you ever stayed overnight in a hospital?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide the approximate date that you left work, duration off work and medical condition.
6. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 5?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide date and describe the medical condition, if not already described above.
7. Have you ever had an application for insurance declined or modified?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year and describe for what reason(s).
8. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe the reason.
9. In the last 12 months have you been taking any prescription medication?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
10. Have you ever been advised to drink less alcohol by your physician, or used drugs (including marijuana) for non-medical reasons in the last 10 years?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide details of when, which product used, and frequency of use per week.
11. Do you drink alcohol?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide type of alcohol and quantity per week.
12. Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco, or nicotine products in any other form?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide which product you use, how much/many per day.

Section #4 Personal Medical History and Lifestyle Information *...continued*

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 6 - Additional Details at the end of this document and provide the number of the question.**

MB = Member **SP** = Spouse **CH** = Child(ren)

13. Have you gained or lost more than 10 pounds in the last 12 months?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please specify weight loss or gain, amount of change in weight, and reason.
14. Current height and weight: MEMBER: _____ m/cm or _____ feet/inches _____ kg or _____ pounds SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds		
15. Do you have a regular healthcare provider? If yes, please advise (in section to the right) Provider's name, address and date and reason of last appointment.	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	
16. Have you been referred to any medical specialists in the last 2 years?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide the name of specialist, type of specialty and medical reason for visit.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe the type and frequency of the activity.
18. Please describe weekly exercise including type of activity, duration and frequency.		

Family History

19. For each applicant, do your parents, siblings, spouse or children suffer or have suffered from any of the following:

- Alzheimer's Disease
- Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer
- Cardiomyopathy
- Dementia
- Diabetes
- Heart Disease
- Huntington's chorea
- Motor Neuron disease
- Multiple Sclerosis
- Parkinson's Disease
- Polycystic Kidney disease
- Retinitis Pigmentosa
- Stroke
- and/or any other hereditary medical condition

▶ **Member:** ☐ **Yes** ☐ **No** ▶ **Spouse:** ☐ **Yes** ☐ **No** ▶ **Children:** ☐ **Yes** ☐ **No**

If yes, please complete the appropriate section below. Use extra paper if required.

Member (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Please provide any additional information that you feel is important:

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.

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;
- Great-West Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Great-West Life to communicate with me about this application using the email address I have provided;
- 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 _____ MMM/DD/YYYY

Spouse Signature _____ Date Signed _____ MMM/DD/YYYY

The Great-West Life Assurance Company
Group Medical Underwriting
PO Box 6000
Winnipeg MB R3C 3A5
Email: groupmed@gwl.ca
TTY Line 1.800.990.6654 (available for the deaf or hard of hearing)

Please return the completed form to the Ontario Principals' Council

Clear Print

Additional Details

This page is to be used if you require **extra space to respond to a question.**
Provide the number of the question you are addressing.

MB = Member **SP** = Spouse
CH = Child(ren)

Question #	Details