REFERENCE NO. GCP: 000555211

COMPETITOR

Application for disability insurance

Instructions to the Financial security advisor (advisor)

- This application should only be submitted where the insured is determined to be eligible under the *General prescreener* on page 1 and the *Medical and lifestyle questionnaire - Prescreener* on page 4.
- Ask and record answers to all questions in the application completely and accurately.
- Print legibly, using dark ink.
- Have the insured initial all applicable changes. No correction fluid should be used.
- Ensure all required signatures are obtained.
- Explain all *Notices* in section 17. Detach and give them to the insured and the owner, as applicable.
- Refer to the *COMPETITOR Underwriting and administration guidelines* manual, product manuals and other published underwriting material for additional information on completion of this form.
- Wage loss replacement plan (WLRP):
  - If the insurance is intended to form part of a WLRP arrangement, review the *Wage loss replacement plan acknowledgement and agreement* section 14 with the insured.
- Conditional insurance agreement (Agreement):
  - Before payment can be taken with the application, the owner must sign the *Acknowledgement by owner* in section 12.
  - Obtain the first monthly premium before giving the Agreement to the owner.
  - The application should be forwarded to Great-West Life within 2 days of completion.

THE Great-West Life ASSURANCE COMPANY

REFERENCE NO. GCP: 000555211

Application for disability insurance to The Great-West Life Assurance Company (Great-West Life)

In this application, "owner" means the person (including an entity, e.g., company, partnership) proposed to be the owner of any policy issued. The terms "insured", "you", and "your" mean the individual proposed to be the insured.

Sales and marketing centre ▸ _____ **Policy number** ▸ _____

General prescreener

Before completing this application, review this *General prescreener* and the *Medical and lifestyle questionnaire – Prescreener* on page 4 with the insured to assist in determining eligibility.

Name of insured (print) :

First ▸ _____ Middle ▸ _____ Last ▸ _____

1. Do you work **at least 35 weeks** per year? ☐ Yes ☐ No
2. In the weeks in which you work, do you work **at least 20 hours** per week and have you done so during the **past 12 months**? ☐ Yes ☐ No
3. Do you earn income of **at least $10,000** per year? ☐ Yes ☐ No
4. Do you read and speak English or French? ☐ Yes ☐ No
5. Have you been a resident of Canada for **at least 12 months**? ☐ Yes ☐ No
6. Are you a Canadian citizen or permanent resident (landed immigrant)? ☐ Yes ☐ No

If no to any of the above questions, the insured is not eligible for coverage and no application should be taken.

If yes to all complete the *Medical and lifestyle questionnaire – Prescreener* on page 4 before continuing.

1. Insured information

1.1 ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐ Other ▸ _____

1.2 **a)** Sex ▸ ☐ M ☐ F **b)** Date of birth (mmm/dd/yyyy) ▸ _____ **c)** Age nearest birthday ▸ _____

1.3 Province of birth (otherwise, U.S.A. state or country) ▸ _____

1.4 Social insurance number (provide if insurance applied for is intended to form part of a wage loss replacement plan (WLRP) arrangement) ▸ _____–_____–_____

1.5 **a)** Home address* ▸ _____
Street number and name City Province Postal code

***If mailing address is listed as a P.O. Box, rural route or general delivery anywhere in this application, record civic address/physical location in question 6 in the *Advisor's report*.**

b) How long have you resided in Canada? ▸ _____ Years

1.6 **a)** Phone numbers: Home ▸ (_____) _____ Work ▸ (_____) _____ Cell ▸ (_____) _____

b) Most convenient time to call, if a customer interview is required ▸ ☐ Day ☐ Evening Time ▸ _____

Note: For more information regarding the customer interview program, see *Notices* section 17.

1.7 **a)** Name of current business or employer ▸ _____

b) Address ▸ _____
Street number and name City Province Postal code

1.8 How long have you been the owner of the business or employed by this employer? ▸ _____ Years

1.9 **a)** Occupation ▸ _____

b)

Duties	% of time	Description
Administrative/office	% ▸	
Manual/physical	% ▸	
Supervision	% ▸	
Sales	% ▸	
Other (specify) ▸ _____	% ▸	

2. Owner information

2.1 Who will be the owner of any policy issued?
Check one

☐ Same as insured

☐ Insured's business

Note: Allowed only **if the insurance applied for is intended to form part of a WLRP arrangement or if the Business overhead protection rider is applied for** and the business is a partnership or is incorporated.

3. Insurance history

3.1 Are you covered by workers' compensation? ☐ Yes ☐ No

3.2 Do you have any long term care or overhead expense insurance, or do you have any individual, association, group, or other disability income insurance, or insurance providing coverage due to hospitalization in force? ☐ Yes ☐ No

If yes, provide details below

Name of company	Type of insurance	Daily or monthly benefit amount	Year issued	Benefit period	Waiting period	Are benefits taxable?	Will coverage be changed (Chg) or replaced (Rpl)?	**If changing**, provide details. **If replacing Great-West Life policy**, provide policy number.
		$				☐ Yes ☐ No	☐ No ☐ Chg ☐ Rpl	
		$				☐ Yes ☐ No	☐ No ☐ Chg ☐ Rpl	
		$				☐ Yes ☐ No	☐ No ☐ Chg ☐ Rpl	
		$				☐ Yes ☐ No	☐ No ☐ Chg ☐ Rpl	

3.3 Are any applications for life, critical illness, long term care, or overhead expense insurance, or any individual, association, group or other disability income insurance, or insurance providing coverage due to hospitalization pending or contemplated? ☐ Yes ☐ No

If yes, provide details _____

_____

4. Financial information

Earned income (see note below)**, as declared for tax purposes:**

4.1 What is your projected earned income for the current year? $ _____

4.2 What was your earned income last year? $ _____

4.3 **If "projected earned income for the current year" exceeds "earned income last year" by more than 10 per cent**, provide an explanation _____

_____

Note: **Earned income** is:

1. **For a salaried or commissioned employee** – the insured's:
   - **a)** Salary, wages, commissions, fees or other remuneration from employment, less any employment expenses that are deductible from income under the Income Tax Act (Canada) – before taxes; and
   - **b)** Other remuneration from employment such as bonuses and contributions to a pension plan, retirement plan, profit-sharing plan or stock savings plan made on the insured's behalf – before taxes.
2. **For a sole proprietor or partner** – the insured's share of business income less the insured's share of business expenses that are deductible under the Income Tax Act (Canada) – before taxes.
3. **For an incorporated business owner** – the earned income as determined under 1 a) and b) above, if applicable, plus the insured's share of pre-tax corporate profits.

The COMPETITOR plan provides coverage for loss of earned income resulting from disability, as defined in the policy. At the time of a claim, verification of your earned income prior to claim will be required.

5. Plan information

5.1 **Check one** of the following to indicate whether you are using the illustration **or** completing the questions below

☐ Request the plan type, plan details, and optional benefit riders contained under the heading *Coverage and premium summary* in the accompanying illustration dated _____

Note: **If applying for accidental death and dismemberment**, also complete 5.5.

☐ Request the plan type, plan details, and optional benefit riders indicated in 5.2 through 5.4

Note: **If applying for accidental death and dismemberment**, also complete 5.5.

5.2 **Base policy**
Off-The-Job coverage – injury only

		Benefit amount	Premium
Benefit period	☐ 24 months or ☐ 36 months or ☐ 60 months		
Benefit start date	☐ 1st day or ☐ 31 days or ☐ 91 days	$ _____ /month	$ _____

5.3 **Optional definitions of disability**

☐ 24-hour sickness protection ☐ 31 days or ☐ 91 days		$ _____
☐ 24-hour injury protection		$ _____
☐ Long term injury protection to age 70	$ _____ /month	$ _____

5.4 **Optional benefit riders providing 24-hour protection**

☐ Business overhead protection	$ _____ /month	$ _____
☐ Hospitalization benefit	$ _____ /per day	$ _____
☐ Accidental death and dismemberment	$ _____ (lump sum)	$ _____
	Policy fee	$ _____
	Total premium	$ _____

5.5 **If applying for the accidental death and dismemberment optional benefit rider:**

a) Who will be the beneficiary in the event of an accidental death? _____

b) Relationship to the insured _____

c) Do you have any accidental death and dismemberment or accidental death benefit insurance in force or pending? ☐ Yes ☐ No

If yes, provide details (name of company, amount, year issued, etc.) _____

_____

d) You must make your beneficiary designation revocable or irrevocable by checking one of the boxes below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your policy without the written consent of the irrevocable beneficiary.

Where Quebec law applies and you have designated your spouse (married or civil union) as beneficiary, the designation will be irrevocable unless you check the box marked “revocable”.

I hereby make the designation ☐ Revocable ☐ Irrevocable

Medical and lifestyle questionnaire

Prescreener

1. Within the **past 5 years**, have you received treatment, been advised to receive treatment or reduce consumption, or joined an organization, because of the use of alcohol or drugs not prescribed by a physician? Yes No
2. Within the **past 5 years**, have you been treated for or had any known indication of blindness, heart attack, stroke or diabetes requiring control by insulin? Yes No
3. Have you ever been treated for or had any known indication of AIDS or any other disorder of the immune system or tested positive for exposure to the AIDS virus (HIV)? Yes No

If yes to any of the above questions, the insured is not eligible for coverage and no application should be taken.

If no to all of the above questions, continue to section 1 on page 1.

6. Health information

If additional space is required for any question from 6.1 through 6.13, provide details in section 8.

6.1 **a)** Name of personal physician or regular walk-in clinic (**if more than 1 physician or clinic consulted in the past 5 years**, list in section 8) ▶ _____

Address ▶ _____
Street number and name City Province Postal code

b) Date last consulted (mmm/yyyy) ▶ _____

c) Reason, diagnosis, treatment and results ▶ _____

_____

6.2 **a)** Height ▶ _____ ft/ins cms **b)** Weight ▶ _____ lbs kgs

c) Within the **past 12 months** have you had a weight loss of more than 10 lbs (4.5 kgs)? Yes No

If yes, provide details ▶ Amount ▶ _____ lbs kgs

Reason ▶ _____

6.3 In the **past 12 months**, have you used tobacco or any nicotine products? Yes No
If yes, provide details below.

Product (check all that apply)	**How many you used and how often**	**Date last used** (mmm/yyyy)
Cigarettes / e-cigarettes	# Used ____ every: Day Week Month Year	
☐ Cigarillos	# Used ____ every: Day Week Month Year	
☐ Pipe	# Used ____ every: Day Week Month Year	
☐ Cigars	# Used ____ every: Day Week Month Year	
Nicotine patch or gum	# Used ____ every: Day Week Month Year	
Other (for example, chewing tobacco, hookah, vaping, snuff, betel nuts, etc.): _____	# Used ____ every: Day Week Month Year	

6.4 Do you drink alcoholic beverages? Yes No
If yes, how many drinks in total do you have weekly (wine, beer, liquor)? _____
(Examples of serving sizes: bottle of beer, glass of wine, or ounce of liquor)

6.5 In the **past 12 months**, have you used marijuana or hashish? Yes No
If yes, provide details below.

How many you used and how often	**Date last used** (mmm/yyyy)
# Used ____ every: Day Week Month Year	

6.6 Have you ever been treated, counselled or gone to meetings for alcohol or drug abuse? Yes No

6.7 Has a healthcare or other professional ever recommended that you get treatment or counselling or limit the amount of alcohol or drugs you use? Yes No

6.8 In the **past 10 years**, have you ever used any drugs or narcotics that weren't prescribed to you (for example, cocaine, LSD, anabolic steroids or amphetamines)? Yes No

If you answered yes to question 6.4, 6.5, or 6.6, we may ask for a customer interview for more information or you may be asked to complete the *Alcohol questionnaire* (form 17-8917) and/or the *Drug questionnaire* (form 17-8918).

Medical and lifestyle questionnaire

6. Health information *(continued)*

6.9 Have you ever had an application for life, critical illness, disability, overhead expense, or long term care insurance declined, postponed or modified in any way? ☐ Yes ☐ No

If yes, provide details _____

6.10 Have you ever made a claim or received a pension, payments or compensation benefits for accident or sickness? ☐ Yes ☐ No

If yes, provide details _____

6.11 Within the **past 3 years** have you been convicted of, or are you currently charged with, any moving traffic violation(s), or has your driver's licence been under suspension or revoked? ☐ Yes ☐ No

If yes, provide driver's licence number, dates and details _____

6.12 **Have you ever been treated for or had any known indication of:**

a) Dizziness, fainting, convulsions, epilepsy, any sleep disorder, or any disorder of the brain or nervous system? ☐ Yes ☐ No

b) Heart attack, stroke, or disorder of the heart or blood vessels? ☐ Yes ☐ No

c) Back pain, disc disease, rheumatism, gout, arthritis, paralysis, polio, fibromyalgia, or disorder, pain or stiffness of the muscles or bones, including joints, back, neck and spine? ☐ Yes ☐ No

If yes to back pain or disease, complete *Back pain questionnaire* in section 9.

d) Disorder of the eyes or ears? ☐ Yes ☐ No

6.13 Within the **past 5 years** have you been absent from work for **more than 15 consecutive days** for health reasons or injury? ☐ Yes ☐ No

7. Additional health information – complete if applying for 24-hour sickness protection

If applying for 24-hour sickness protection, answer questions 7.1 through 7.5.

7.1 Have any of your immediate family members (father, mother, brothers or sisters) had heart disease, high blood pressure, cancer (specify type), diabetes (specify if type 1 or type 2), kidney disease, Huntington's chorea, or any other hereditary disease? ☐ Yes ☐ No

If yes, provide details _____

7.2 **Have you ever been treated for or had any known indication of:**

a) Asthma, bronchitis, allergies, pleurisy, emphysema, persistent cough, or disorder of the lungs or respiratory system? ☐ Yes ☐ No

b) Headaches, high blood pressure, chest pain, elevated cholesterol or heart murmur? ☐ Yes ☐ No

c) Ulcer, recurrent indigestion, rectal bleeding, colitis, jaundice, hepatitis including hepatitis carrier, hemorrhoids, hernia, or disorder of the stomach, intestines, rectum, gall bladder, liver or pancreas? ☐ Yes ☐ No

d) Sugar, albumin, pus or blood in the urine, nephritis, kidney stone, or disorder of the kidneys, bladder, prostate, breast or reproductive organs? ☐ Yes ☐ No

e) Cancer, tumour, skin disease, sexually transmitted disease, enlarged lymph glands, anaemia, or disorder of the glands or blood? ☐ Yes ☐ No

f) Diabetes or disorder of the endocrine system including thyroid gland, adrenal gland and pituitary gland? ☐ Yes ☐ No

g) AIDS or any other disorder of the immune system or tested positive for exposure to the AIDS virus (HIV)? ☐ Yes ☐ No

7.3 Have you ever received treatment or counselling for or had any known indication of burnout, chronic fatigue, anxiety, depression, or any psychiatric disorder? ☐ Yes ☐ No

Medical and lifestyle questionnaire

7. Additional health information *(continued)*

7.4 Have you taken any prescribed medication or received any treatment or therapy in the **past 12 months**? ☐ Yes ☐ No

If yes, provide details including medication and date last prescribed _____

_____

_____

Genetic Non-Discrimination Act

You should not tell us about any genetic test (that is, any analysis of DNA or RNA chromosomes) which you may have had. You must however, tell us if you are having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

7.5 **Within the past 5 years have you:**

a) Had a check-up, illness, surgery, injury or disease not mentioned in questions 7.1 through 7.4? ☐ Yes ☐ No

b) Been a patient in a hospital, clinic, rehabilitation or other medical facility? ☐ Yes ☐ No

c) Had an electrocardiogram, X-ray, blood tests or other diagnostic tests (other than a genetic test)? ☐ Yes ☐ No

If yes to any question in 7.1 through 7.5, or if additional space was required, provide details in section 8 below.

8. Additional health information details

If yes to any question in 6.12 or 6.13, or in 7.2 through 7.5, or if additional space was required, provide details in the chart below.

Question number	Conditions / symptoms, duration, tests, results and treatment	Date (mmm/yyyy)	Name and address of physician, clinic and/or hospital

Attach a sheet if more space is required (include application number, date and insured's signature).

Medical and lifestyle questionnaire

9. Back pain questionnaire – complete **if yes** to 6.12 c)

9.1 Date of first episode ▸ Month _____ Year _____ Duration of discomfort ▸ _____

9.2 Date of last episode ▸ Month _____ Year _____ Duration of discomfort ▸ _____

9.3 Longest duration of discomfort of any other episode ▸ _____ Date ▸ Month _____ Year _____

9.4 Date of last treatment ▸ Month _____ Year _____

9.5 Give diagnosis, if known ▸ _____

_____

_____

9.6 What is the frequency of your back pain? ☐ Once a year ☐ 2 - 5 a year ☐ Over 5 a year

9.7 What area(s) of the back was involved? ☐ Neck (cervical) ☐ Middle (thoracic) ☐ Low (lumbosacral)

9.8 Does the pain radiate? ☐ Yes ☐ No

If yes, where does it radiate to? ▸ _____

_____

_____

9.9 Do you currently have any restriction of back movement? ☐ Yes ☐ No

9.10 **In relation to your back pain, have you ever:**

a) Undergone any x-rays or other investigation of your back? ☐ Yes ☐ No

b) Had or been advised to have surgery? ☐ Yes ☐ No

c) Been hospitalized for any back complaints? ☐ Yes ☐ No

d) Been disabled or unable to work because of your back discomfort? ☐ Yes ☐ No

e) Had chiropractic treatment for your back? ☐ Yes ☐ No

9.11 **If yes to any question from 9.10 a) through e)**, provide full name of physicians, chiropractors or therapists consulted, and dates ▾

_____

_____

_____

_____

10. Business overhead protection rider information – complete if applied for in section 5

10.1 Do you own **at least 20 per cent** of the business? ☐ Yes ☐ No

10.2 **a)** Number of full-time employees _____

b) Number of part-time employees _____

10.3 List **your share** of the average monthly expenses incurred in the operation of your office or business:

a) Salaries and benefits – excluding remuneration for you or any member of your profession and remuneration of any employee whose duties or technical skills generate income for the business .... $ _____

Complete the chart below for the employees whose salaries are being insured

Name	Duties	Monthly salary
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$

b) Telephone, communication services – excluding long distance charges ..... $ _____

c) Other taxes – business, payroll ..... $ _____

d) Leasing costs for furniture or equipment ..... $ _____

e) If furniture or equipment is owned, interest plus the greater of scheduled depreciation or scheduled loan principal payment ..... $ _____

f) Accounting and legal services ..... $ _____

g) Membership fees ..... $ _____

h) Business insurance premium ..... $ _____

i) Utilities* – electricity, heat, water ..... $ _____

j) Property taxes* ..... $ _____

k) Rent* ..... $ _____

l) If premises are owned, mortgage interest plus the greater of scheduled depreciation or scheduled mortgage principal payment – use only the portion that applies to the space used in the operation of your office or business* ..... $ _____

m) Other fixed monthly expenses – itemize if greater than 10 per cent of total

_____ $ _____

_____ $ _____

Total monthly expense $ _____

*__If your office is located in the home__, these expenses plus any other expenses which are related to the home are not eligible.

10.4 Outline in detail any special technical qualifications and skills you provide and why these are of such a nature that the business could not be properly maintained in the event of disability

_____

_____

_____

_____

11. Premium/payments

11.1 Premium payor

Check one and complete as applicable

☐ Insured

☐ Owner

Note: Premium notices will be sent to the premium payor.

☐ Other: Full name (first, middle, last) _____

Address _____
Street number and name | City | Province | Postal code

11.2 Method of payment

Check one and complete as applicable

☐ Annual payment

☐ Automatic premium payment (Autopay) – complete 11.3

☐ Mass billing

☐ Salary deduction
Check one ☐ Regular ☐ Autopay – complete 11.3

Note: Any premium payment frequency other than annual results in a higher annualized premium. Subject to Great-West Life's approval, the premium payor may change the premium payment frequency to another frequency then available.

11.3 Automatic premium payment (Autopay) agreement request

Complete this section to make premium payments by pre-authorized monthly withdrawal from the account holder's financial institution.

Check one of the following 4 options, and sign as applicable in section 15 after reading the *Terms and conditions of the Autopay agreement* in section 18.

☐ Existing Autopay on policy number _____

☐ Concurrent application number _____

☐ Attached cheque marked "VOID"

☐ Account information indicated in the cheque illustrated below

Print name of account holder: _____ 561

Print name of joint account holders, if any: _____ DATE _____

PAY TO THE ORDER OF _____ $ _____

Name of financial institution: _____ **Transit #** (ScotiaBank only): _____

Address: _____

Type of account: ☐ **Personal chequing** ☐ **Current/business** ☐ **Savings**

⑈ 561 ⑈ **Transit #:** _____ ⑈⑈ **Bank code:** _____ ⑈ **Account no.:** _____ ⑈

Note: **If attaching a VOID cheque or if completing the illustrated cheque above**, the premium withdrawal day will be the same day of each month as the new policy date, unless you specify a different day

☐ **Use a different withdrawal day** – specify which day of the month (choose any day of the month from the 1st to the 30th) Withdrawal day

12. Acknowledgement by owner

The owner acknowledges receipt of the conditional insurance agreement, having read and understood it, and agrees to all its terms and conditions.

Signature of **owner**	
X	
Signature of **witness** X	Date (mmm/dd/yyyy)

This acknowledgement must remain attached to the application.

13. Conditional insurance agreement and receipt (detach and give to owner)

The Great-West Life Assurance Company (Great-West Life) Conditional insurance agreement (Agreement) provides, in certain circumstances, coverage for limited amounts. This agreement is subject to the terms and conditions of any policy issued and is further limited by the following additional terms and conditions:

1. There is NO INSURANCE COVERAGE under this agreement:
   a) UNLESS the proposed insured is later found to have been insurable under Great-West Life's underwriting rules and practices (on the terms applied for or on modified terms acceptable to the owner) on the date(s) when both the application (which wherever referred to in this agreement, includes sections 1 through 10, and any supplement to the application) and any paramedical, medical exam, or medical tests which may be required by Great-West Life were fully completed;
   b) UNTIL the payment acknowledged by the receipt below is paid; and
   c) UNTIL the application and any paramedical, medical exam, or medical tests which may be required by Great-West Life have been fully completed.
2. No amount will be paid under this agreement if the insured fails to disclose or misrepresents facts within his/her knowledge which are material to the insurance.
3. Acceptance by Great-West Life of the payment acknowledged by the receipt below does not bind Great-West Life to provide coverage under this agreement. Where it is determined that no coverage will be provided under this agreement, any payment made will then be refunded.
4. This agreement will become effective as of the date on which both conditions 1 b) and 1 c) have been satisfied, provided that the condition in 1 a) is also satisfied.
5. The total amount of insurance coverage provided by this and any other conditional insurance agreement issued by Great-West Life, is limited to the lesser of the amount applied for and the following amounts:

Injury or sickness protection rider or business overhead protection rider	– $1,000 monthly or the amount of monthly income benefit for total disability which is approved by Great-West Life, if less.
Hospitalization benefit rider	– $100 daily or the amount of hospitalization benefit approved, if less.
Accidental death and dismemberment	– $100,000 or the amount of accidental death and dismemberment approved, if less.

6. The agreement will end automatically on the earliest of: a) The date the policy applied for becomes effective; b) The date Great-West Life determines no coverage will be provided under this agreement; and c) 90 days after the date this agreement is signed.
   Great-West Life may continue to process the application, but the conditional insurance coverage will no longer be in effect. The payment or part of it submitted with this application may be retained during this time and applied to the policy if issued, or refunded to the owner if not issued. Any delay in refunding does not extend the conditional insurance coverage.

No advisor is authorized to modify this agreement.

Receipt

The Great-West Life Assurance Company acknowledges receipt of $ _____ . This amount is to be applied toward the initial premium for any policy issued to the application whose number appears on this receipt.

Note regarding conditional insurance: Any amount paid or promised to be paid, or acknowledged as received, does **not** by itself bind Great-West Life to provide conditional insurance coverage or the policy applied for. All terms and conditions for conditional insurance coverage must be met.

Signature of **advisor**	City	Province	Date (mmm/dd/yyyy)
X			

REFERENCE NO. GCP: 000555211

14. Wage loss replacement plan acknowledgement and agreement – if applying for insurance intended to form part of a wage loss replacement plan

Please read this entire section carefully before signing the *Agreement, declaration, authorization, and signatures* section 15.

The owner and the insured acknowledge and agree that:

1. The individual disability insurance policy applied for or issued by Great-West Life is intended by the owner to form part of an arrangement of individual disability insurance policies in order to constitute a group sickness or accident plan acceptable to the Canada Revenue Agency (CRA) for income tax purposes. A group sickness or accident plan must either already exist or must be properly implemented immediately by the owner of the policy. For the purpose of the policy, this arrangement is referred to as a "wage loss replacement plan".
2. The owner is solely and completely responsible for properly implementing and maintaining a wage loss replacement plan acceptable to the CRA. In accordance with one of CRA's requirements, any monthly benefit amount must be and remain payable to the insured.
3. The owner is solely and directly responsible for paying all premium due under the policy, if issued. Any monthly benefit amount payable will be reported as taxable income of the insured.
4. If a wage loss replacement plan acceptable to the CRA is not properly implemented and maintained:
   a) the premium paid by the owner may be disallowed retroactively by the CRA as a tax deductible expense; and
   b) the CRA may require the insured to retroactively include the amount of premium paid as a taxable employee or shareholder benefit in calculating his or her personal income taxes. Interest and penalties may also apply.

15. Agreement, declaration, authorization, and signatures

This application consists of the pages within this booklet and such other documents as by written agreement are to form a part of this application. **The agreement, declaration and authorization set out below pertain to the entire application and should be read carefully before signing.**

A. The insured, and the owner, if other than the insured, acknowledge and agree that:

1. Statements and answers to questions in this application relate to the insured.
2. Any information given over the telephone to a paramedical company representing Great-West Life or London Life, and information given during a customer interview as outlined in the *Notice regarding customer interview program*, forms a part of this application. Any recording, transcription or other notation (collectively "recording") received in this manner will be considered accurate, complete and binding as if it were given in writing by the above named individual(s), as applicable. However, where Great-West Life provides me with a copy of a recording, I agree to review it immediately and contact Great-West Life, without delay, if I question or dispute its accuracy or completeness.
3. No information, statements, representations or answers with respect to any question in this application shall be deemed to have been communicated to or binding on Great-West Life unless contained in this application.
4. Except as provided in the *Conditional insurance agreement*, if issued, any policy issued pursuant to this application shall not take effect until: a) the policy is delivered, b) the first premium is paid, and c) no change has taken place in the insurability of the insured, subsequent to the completion of this application.
5. If this application is accepted and a policy is issued and put into effect, and the change or replacement agreed to in question 3.2 is not proceeded with, benefits will not be granted under the policy.
6. A copy of this application will not be automatically delivered with the policy (except in the province of Quebec, in accordance with provincial law, or where required by other provincial law). A copy of this application will be made available upon request.
7. No advisor is authorized to amend, alter, modify or waive the terms of this application, or any contract of insurance issued.
8. If the application involves an increase of monthly income benefits or the addition of an optional benefit rider to an existing policy, the Incontestability provision of the existing policy will apply to the increase or the addition from the Effective Date of such increase or addition.
9. If the initial payment submitted with the application must be refunded for any reason, it will be returned to the owner.
10. Any change in the insurability of the insured following the completion of this application and prior to the delivery of the policy, if known by the insured, must be communicated to Great-West Life without delay.

(continued on next page)

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15. Agreement, declaration, authorization, and signatures *(continued)*

A. *(continued)*

11. If under section 5 an illustration is to be used to provide information on plan type, plan details, and optional benefit riders, then despite anything to the contrary contained in the illustration, this information and only this information from the illustration, referred to in section 5, shall form part of this application.

B. The insured, and the owner, if other than the insured, declare that:

1. I have read all the statements, questions and answers made in this application, and understand that they will form the basis of any policy issued.
2. To the best of my knowledge and belief the answers and statements given in this application are complete and true. It is understood that if any statement or answer in this application misrepresents or fails to disclose any fact material to the insurance, any policy issued as a result of the application may be voided.
3. I have received, read, understand and agree with the *Notices* in section 17 regarding Great-West Life, personal information, 10 day right to examine policy, tax treatment, customer interview program, MIB, Inc. (MIB), summary of policy benefits, and investigative consumer report.
4. If the insurance applied for is intended to form part of a WLRP:
   a) I authorize and consent to Great-West Life's use of my social insurance number for tax reporting, identification, and record keeping purposes.
   b) I have read, understood, and agree to the *Wage loss replacement plan acknowledgement and agreement* in section 14.

C. The insured consents to a personal interview containing personal information or credit information, or both, that may be requested in connection with this application.

D. The insured, and the owner, if other than the insured, have expressly requested that this application and the policy, and all related documents be drafted in English. L'assuré, et, s'il n'est pas l'assuré, le propriétaire ont demandé expressément que la présente proposition et la police, ainsi que tous les documents qui s'y rapportent, soient rédigés en anglais.

E. The insured authorizes any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, any motor vehicle department concerning driving records, or other organization, institution or person that has any records or knowledge of me or my health to give Great-West Life (or any organization acting on its behalf) or its reinsurer(s) any such information. A copy of this authorization shall be as valid as the original.

F. The insured, and the owner if other than the insured, authorize and consent to Great-West Life and reinsurers making a brief report to MIB and releasing my medical findings and test results to the physician or walk-in clinic indicated in 6.1 upon my request.

G. This authorization is valid until revoked in writing by the undersigned, subject to legal and contractual restrictions which may apply. The undersigned acknowledges that I am aware of the reasons the information covered by this consent is needed, as well as of the benefits and risks of consenting or not consenting.

Signed at:

_____ on _____

City | Province | Date (mmm/dd/yyyy)

Signature of **owner** (if business, authorized person to sign **and** indicate title)	**If owner is a business**, print full legal name of the business
X	
Signature of **insured**, if other than owner	Signature of **account holder***, if other than owner
X	X
Signature of **witness** to all signatures	Signature of **other joint account holder(s)***, if required for account
X	X

***Account holder(s) also acknowledge(s) receipt of the *Terms and conditions of the Autopay agreement* – section 18.**

16. Authorization to obtain information

For underwriting, administration and claim purposes, I authorize and consent to: any physician, medical practitioner, hospital or medically related facility, insurance company, MIB, Inc., motor vehicle department, or other organization, institution or person, that has information concerning me or my health, to give Great-West Life and reinsurers any such information (including record copies), and to Great-West Life and reinsurers collecting such information.

I am aware of the reasons the personal information covered by my authorizations and consents is needed, and of the benefits of, and the risks of not, authorizing/consenting. This and all authorizations and consents concerning personal information are given in accordance with applicable law. They will begin the date they are given (the date of this application, unless indicated otherwise) and end when no longer required. They may be revoked at any time by either written or electronic notification to Great-West Life, subject to legal or contractual considerations. **A reproduction of the above authorizations and consents will be as valid as the original.**

Signed at:

_____ on _____

City | Province | Date (mmm/dd/yyyy)

Signature of **insured**	Signature of **witness** to all signatures
X	X

17. Notices – detach and give to owner(s)/insured(s)

In this section, "insured" means the individual proposed to be the insured. "We", "us" and "our" mean The Great-West Life Assurance Company.

Notice regarding The Great-West Life Assurance Company (Great-West Life)

Great-West Life, a member of the Power Financial Corporation group of companies, provides insurance and wealth management products and services. For current information on Great-West Life's ratings and financial strength, and for more information on our products and services, see our website www.greatwestlife.com.

Notice regarding personal information

Further to an application for any product or service, Great-West Life establishes a confidential file that contains personal information concerning the insured. The file is kept in the office of Great-West Life or of third-parties acting on our behalf. Rights of access to personal information in the file are limited to our staff or persons authorized by us (e.g., service providers, your advisor), whether located in Canada or elsewhere, who require it to perform their duties, to the insured or parent or legal guardian of a child insured, and persons to whom the insured or parent or legal guardian of a child insured has granted access, and, as personal information may be collected, used, retained, or disclosed in or from Canada or elsewhere, access may be had by persons authorized by the laws of Canada or elsewhere, as applicable. The insured's, or parent or legal guardian of any child insured's, rights of access and correction of any inaccuracies may be exercised by writing to The Ombudsman, The Great-West Life Assurance Company, 255 Dufferin Avenue, London, Ontario, Canada N6A 4K1. We collect, use, retain and disclose the insured's personal information to: **(1)** process this application and, if this application is approved, provide and service the financial product(s) and/or service(s) applied for, **(2)** advise the insured or parent or legal guardian of any child insured by telephone or otherwise of products and services to help plan for financial security, **(3)** respond to, investigate and process claims, **(4)** create and maintain records concerning our relationship as appropriate, and **(5)** fulfill such other purposes as are directly related to the preceding. **Note:** In accordance with legal requirements, a copy of the entire application, including personal information, may be included with the policy as delivered or be provided separately to the owner or a subsequent owner.

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.

Notice regarding 10 day right to examine policy

Within ten days after receiving the policy applied for (or where permitted by law within 60 days after its effective date if the policy has been issued but not received by the owner), the owner may cancel it. If cancelled, the policy will be void from the start and all premium paid for the policy will be refunded. The same right applies to any rider issued after the policy is in force from the date the rider is received. Please return the policy or rider if requesting a cancellation.

(continued on next page)

18. Terms and conditions of the Autopay agreement – detach and give to owner if applied for in section 11

Automatic premium payment (Autopay) agreement request

The following *Terms and conditions of the Autopay agreement* are applicable if the premium payment method chosen in 11.2 was automatic premium payment and a new Autopay is being set up based on completed information in 11.3. It is important that all account holders sign in section 15. Autopay agreements are within the category of "pre-authorized debit agreements", a term used by the Canadian Payments Association.

Note: The Autopay agreement will commence on or after the date of this application. The payments made under this Autopay agreement are subject to the provisions of any policy issued pursuant to this application or to which this Autopay agreement may otherwise apply (including provisions for when a payment is due under a policy; a withdrawal date under this Autopay agreement that is different than the date a payment is due does not change that due date). References in this form to "this Autopay agreement" include later amendments to it.
If the account holder is other than the owner, the advisor should make a copy of the Terms and conditions of the Autopay agreement and provide it to the account holder.

Terms and conditions of the Autopay agreement

Authorization	I, the account holder, authorize The Great-West Life Assurance Company (Great-West Life) and my financial institution named in 11.3 (a copy of 11.3 is available from Great-West Life upon request), to withdraw monthly from my account any payments that I have agreed to make under this Autopay agreement as though I had personally signed a cheque. I understand that changes to the policy(ies), including as applicable, to premium amounts or to the method or required amount of payment, or termination and recommencement of automatic premium payments under this Autopay 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 Life'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 Autopay agreement. If I am not also the owner of a policy covered by this Autopay agreement, I authorize Great-West Life to share with the owner(s) of such policy any information relating to this Autopay agreement, including the payments and their source. I agree that a photocopy or electronic copy of this Autopay agreement will be as valid as the original.
Signatures	I certify that all persons whose signatures are required to authorize this Autopay agreement have signed in section 15, including any required joint account holder.

(continued on next page)

REFERENCE NO. GCP: 000555211

17. Notices *(continued)*

Notice regarding tax treatment

Any tax information provided is for general information only. It is not to be relied upon as providing legal or tax advice. The owner should consult with their own professional legal and/or tax advisor to address their particular circumstances.

Notice regarding customer interview program

In connection with the application for insurance, the insured or parent or legal guardian of a child insured may receive a telephone call from an authorized person to obtain some personal and financial information. Be assured that the information is confidential and will be used only to assess the insured's eligibility for insurance. The interview normally takes from fifteen to twenty minutes and will be conducted at a time convenient to the insured or parent or legal guardian of a child insured. If such person is not in when the interviewer calls, the interviewer will leave his/her name and a telephone number so that the call can be returned at no charge to supply the necessary information.

Notice regarding MIB, Inc.

Information regarding the insured's insurability will be treated as confidential. However, we and our reinsurers may make a brief report thereon to MIB, Inc. (MIB), formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies operating an information exchange on behalf of its members. If an application to another MIB member company for life or health insurance coverage is submitted for the insured, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request with appropriate authorization, MIB will arrange disclosure of any information it may have in the insured's file. If the accuracy of information in MIB's file is in question, contact MIB and seek a correction, either by writing to MIB, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7 or by telephoning 416-597-0590.

We and our reinsurers may also release information in our file to other insurance companies which have received applications for life or health insurance on the insured, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Notice regarding summary of policy benefits

The policy applied for contains many valuable features and benefits. However, be aware that the policy may be subject to certain exceptions and potential reductions in benefits. These features and benefits can be described in full detail by the advisor and are described in the Summary of Policy Benefits which will be delivered with the policy.

Notice regarding investigative consumer report

As part of our procedure for processing the application for insurance, an investigative consumer report which may include credit or personal information or both may be prepared. The insured or parent or legal guardian of a child insured has the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

18. Terms and conditions of the Autopay agreement *(continued)*

Account changes	I will notify Great-West Life 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 Life may, but is not obligated to, rely on verbal instructions from me to amend this authorization.
Transfer of ownership	I understand that if ownership of a policy is transferred or the policy is assigned, pre-authorized payments will continue to be withdrawn from my account unless I notify Great-West Life that they are to stop.
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 Life 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.
Non sufficient funds (NSF) information	If there is not enough money in my account to cover the monthly amount due ("due" as an amount owing, or as an amount otherwise specified to be withdrawn under this Autopay agreement), I authorize Great-West Life to immediately make a second attempt to withdraw the amount due. If the second attempt is also returned NSF (or if Great-West Life decides, in its sole discretion, not to make the second attempt), I understand that pre-authorized payments will be suspended and possibly cancelled by Great-West Life. 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 Life of the assignment by Great-West Life of this Autopay agreement.**
Recourse	I have certain recourse rights if any debit does not comply with this Autopay agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Autopay agreement. To obtain more information on my recourse rights, I can contact my financial institution or visit www.cdnpay.ca.
Cancellation	This Autopay 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 or the owner(s) to Great-West Life or by Great-West Life to me or the owner(s). To obtain a sample cancellation form, or for more information on my right to cancel this Autopay agreement (a pre-authorized debit agreement), I can contact my financial institution or visit www.cdnpay.ca. To obtain more information on my Autopay agreement, I can contact Great-West Life at 1-800-665-0551 or at 60 Osborne St. North, PO Box 6000, Winnipeg, Manitoba, R3C 3A5. I as the owner, agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Great-West Life, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Great-West Life, in its sole discretion, may require a new written Autopay agreement if this Autopay agreement is cancelled for any reason.

REFERENCE NO. GCP: 000555211

Advisor's report

The Advisor's report does not form part of the application. In this section "insured" means the individual proposed to be the insured and "you", "your", and "I" mean the advisor.

1. Is the insurance applied for intended to:

a) Form part of a WLRP arrangement? ☐ Yes ☐ No

If yes, is the insured a salaried employee or owner of an incorporated company? ☐ Yes ☐ No

b) Form part of a group other than a WLRP? ☐ Yes ☐ No

Note: If insurance is intended to form part of a WLRP arrangement, review the *Wage loss replacement plan acknowledgement and agreement* section 14 with the insured.

2. **If yes to 1 a) or b)**, provide details of other policies or applications associated with this group below

Name of insured (first, last)	Date of birth (mmm/dd/yyyy)	Policy or application number

3. What is the insured's marital status? ☐ Single ☐ Married ☐ Common-law/civil union (Quebec) ☐ Widow/widower ☐ Separated ☐ Divorced ☐ Other (specify) _____

4.

Advisor's name (print first, last)	Great-West Life commission account number (6 digits)	% share of commission	Cash flow
		%	☐ CCF ☐ ICF
		%	☐ CCF ☐ ICF
		%	☐ CCF ☐ ICF

5. Payment of $ _____ received _____ date (mmm/dd/yyyy).

6. Provide any other relevant information here. Attach a separate sheet if additional space is required (include application number, date and your signature).

_____

_____

_____

_____

_____

_____

7. I certify that I have asked all questions and fully recorded all the answers given by the insured on the application. I know nothing that is material to the insurability of the insured that has not been recorded. I have provided the following information in writing to the owner: **a)** the company or companies I represent; **b)** that I receive compensation (such as commissions) for the sale of life and health insurance products; **c)** that I may receive additional compensation in the form of bonuses, conferences, or other incentives; and **d)** any actual or potential conflicts of interest I may have with respect to this transaction.

Signature of **advisor**	City	Province	Date (mmm/dd/yyyy)
X			