THE Great-West Life ASSURANCE COMPANY

Application for Accidental Disablement or Specific Loss - Employer / Policyholder Statement

Group Policy No.: 330780 Certificate No.: _____ Division No.: _____

Name of Employee: _____ Employee No: _____

Address: _____

Date of Birth: _____ Date of Employment: _____

Amount of Accidental Dismemberment or Loss Benefit: $_____ Date last reported for work prior to accident: _____

Salary or wages as of date last reported for work:

☐ Hourly $ _____ ☐ Bi-weekly $ _____ ☐ Monthly $ _____ ☐ Annually $ _____

No. of hrs/week _____ Date of last increase _____

Amount of last increase _____ Insurance class _____

Has the employee returned to work? ☐ Yes ☐ No

If reason for leaving was other than the accident please give details. _____

_____

_____

_____

_____

_____

_____

Employer: _____

Date _____ _____

SIGNATURE AND TITLE

RETURN COMPLETED FORM TO CIVIL SERVICE SUPERANNUATION BOARD

THE Great-West Life ASSURANCE COMPANY

Application for Accidental Disablement or Specific Loss-Claimant's Statement Part 1

INSTRUCTIONS

1. **COMPLETE PART 1 AND AUTHORIZATION ON THE LAST PAGE OF PART 2. ASK YOUR PHYSICIAN TO COMPLETE PART 2.**
2. **AFTER PART 2 IS COMPLETED, INSERT IT INTO AN ENVELOPE AND SEAL IT (FOR CONFIDENTIALITY).**
3. **SECURELY ATTACH PART 1 TO THE SEALED ENVELOPE CONTAINING PART 2.**
4. **FORWARD BOTH PART 1 AND PART 2 TOGETHER TO:**
   CIVIL SERVICE SUPERANNUATION BOARD
   1200 - 444 St Mary Ave
   Winnipeg, MB R3C 3TI

Group Policy No. 330780 Certificate No. _____

Name: _____

Address: _____
Street City Province Postal Code

Please check which Dismemberment or Specific Loss is being applied for:

- ☐ The Sight of both eyes
- ☐ One hand and one foot
- ☐ One arm or one leg
- ☐ Both the thumb and index finger of one hand
- ☐ Either both hands or both feet
- ☐ The sight of one eye and either one hand or one foot
- ☐ One hand or one foot or the sight of one eye
- ☐ Total & Permanent Disability

Date of Accident: _____ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred: _____

_____

_____

Name of hospital if you were confined: _____

Dates of hospitalization: _____

Name of Attending Physician: _____

Physician's Address: _____
Street City Province Postal Code

Date of first treatment: _____

* If yes, please provide your accident report.

AUTHORIZATIONS AND DECLARATIONS

Protecting your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. Personal information about you is kept in confidential files in the office 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 collect, use and disclose the personal information to administer the plan, investigate and assess claims, and create and maintain records concerning claims.

Authorizations and Declarations

I authorize:

Great-West Life, any physician, surgeon or any other person who has examined me, any hospital in which I have received treatment, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life or working with my plan administrator, to exchange information, when relevant and necessary for the purpose of assessing my claim and to administering the plan;

I hereby declare that the answers given by me are, to the best of my knowledge and belief, true and full, and I have withheld no material facts from Great-West Life.

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

Signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

Application for Accidental Disablement or Specific Loss Attending Physician's Statement Part 2

Patient's Name: _____

Patient's Address: _____

Group Policy Number: 330780 Certificate No.: _____

1. (a) When did the accident happen? Month _____ Day _____ Year _____

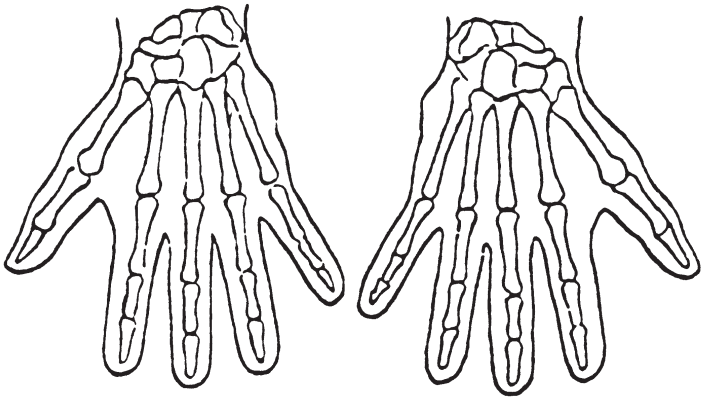
   (b) Briefly describe details of the accident. _____

2. (a) Date of first attendance for present injury. Month _____ Day _____ Year _____

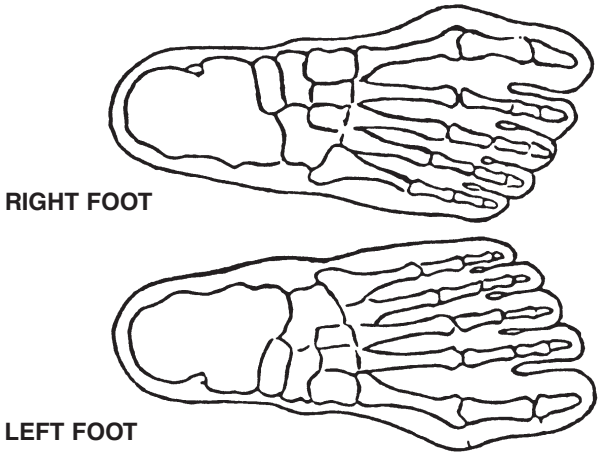
   (b) Date of most recent treatment. Month _____ Day _____ Year _____

3. (a) If the accident caused the loss of hand(s), foot (feet), arm, leg, or thumb and index finger of same hand, please indicate the point of amputation on the diagram below.

   (b) Date of amputation. Month _____ Day _____ Year _____

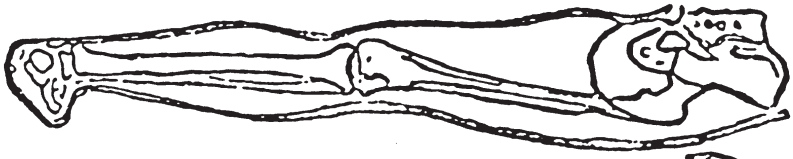


LEFT HAND RIGHT HAND

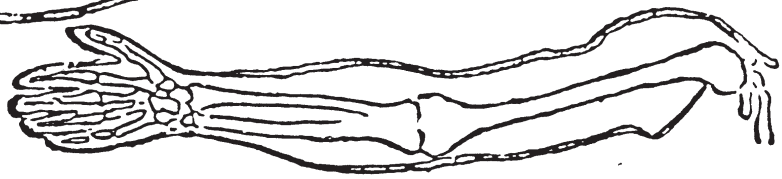


RIGHT FOOT

LEFT FOOT



INDICATE WHETHER RIGHT OR LEFT



4. (a) If the accident caused loss of **use** of leg, arm, hand(s), foot (feet) or thumb and index finger of same hand, please advise which.

(b) Is there any indication that the injured limb was unable to function normally prior to accident? ☐ Yes ☐ No

(c) Please indicate what functions, if any, the injured limb is able to perform.

5. (a) Was the injury described solely responsible for the loss? ☐ Yes ☐ No

(b) If not, give particulars of any contributing cause or causes.

LOSS OF SIGHT ONLY

6. If the accident caused total and irrecoverable loss of sight, please indicate:

(a) Date on which loss occurred. Month _____ Day _____ Year _____

(b) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

(c) If known to you, please advise the vision in each eye prior to the accident.

(d) What is the best corrected vision in the affected eye(s), if any?

7. Is this employee permanently and totally disabled (state of incapacity that permanently, continuously and wholly prevents an employee from engaging in any occupation and from performing any work for remuneration or profit)?

Date _____ Signed _____ M.D.

Print Name _____

Address _____
Street City Province Postal Code

Authorizations and Declarations

I authorize:

Great-West Life, any physician, surgeon or any other person who has examined me, any hospital in which I have received treatment, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life or working with my plan administrator, to exchange information, when relevant and necessary for the purpose of assessing my claim and to administering the plan;

I hereby declare that the answers given by me are, to the best of my knowledge and belief, true and full, and I have withheld no material facts from Great-West Life.

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

Signature _____ Date _____