THE Great-West Life ASSURANCE COMPANY

DEPENDENT INSURANCE MEDICAL QUESTIONNAIRE

Great-West Life
your Benefits Solutions People

INSTRUCTIONS **Employee:**
1. Complete, sign and date the Medical Questionnaire.
2. For confidentiality purposes insert the Medical Questionnaire in a sealed envelope indicating your name and employee number. Attach this sealed envelope to Form 8002.
3. Return to your employer.

THE GREAT-WEST LIFE ASSURANCE COMPANY
GROUP MEDICAL UNDERWRITING
P.O. BOX 6000
WINNIPEG, MANITOBA R3C 3A5
TELEPHONE 204.946.8554
TTY LINE 1.800.990.6654
(available for the deaf or hard of hearing)

Name of Group Policyholder (Employer)	Group Policy No.	Division No.
THE PROVINCE OF MANITOBA	**330785**	

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Miss ☐ _____ | Employee Last Name | First Name | Middle Name

Home Mailing Address | Street | City | Province

Postal Code | Home Phone No. ( ) | Business Phone No. ( ) ext.

SPOUSE / CHILDREN INFORMATION (if applicable). If you require more space, complete additional form.

	FIRST NAME LAST NAME	Sex	Date of Birth Month	Day	Year	Height	Weight
Spouse		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb
Child (1)		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb
Child (2)		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb
Child (3)		☐ Male ☐ Female				☐ m/cm ☐ ft/in	☐ kg ☐ lb

THE FOLLOWING QUESTIONS SHOULD BE ANSWERED FOR EACH INDIVIDUAL WHO IS APPLYING FOR COVERAGE. IF THIS APPLICATION IS FOR A DISABLED DEPENDENT OVER AGE 22, PROCEED TO QUESTION 19.

Spouse's Occupation: _____

Has your spouse or your children:	SPOUSE Yes	SPOUSE No	CHILDREN Yes	CHILDREN No
1. had any ailment, injury or illness in the past five years which caused the individual to be away from work or school for 10 days or more?	☐	☐	☐	☐
2. ever had high or low blood pressure, high cholesterol (and if so, advise if any treatment and most recent level), pain or tightness in the chest, or any heart disorder including disorders of the circulatory system?	☐	☐	☐	☐
3. ever had cancer, disorders of the blood, diabetes, hepatitis, liver disorder, kidney, respiratory or intestinal disorders?	☐	☐	☐	☐
4. ever had convulsions, loss of consciousness, fainting spells, severe headaches, nervous breakdown, mental illness, anxiety, depression, chronic fatigue syndrome, cerebral palsy, stroke, or any disorder of the nervous system?	☐	☐	☐	☐
5. ever had backache, rheumatic fever, rheumatism, arthritis, paralysis, fibromyalgia, or disorder of the muscles or bones, including joints, spine and skin?	☐	☐	☐	☐
6. had any disorder of eyes, ears, nose or throat?	☐	☐	☐	☐
7. had AIDS or other disorder of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	☐	☐	☐	☐
8. ever been in a hospital, sanitarium or other institution for treatment or observation?	☐	☐	☐	☐
9. any reason to believe you will require medical or surgical treatment during the next 12 months?	☐	☐	☐	☐
10. ever taken drugs, other than for medical purposes, been advised to drink less alcohol or received treatment for drug addiction or alcoholism?	☐	☐	☐	☐
11. ever had any serious illness or injury since childhood not mentioned above?	☐	☐	☐	☐
12. had X-rays, electrocardiograms, blood or other special tests, for other than regular medical checkups in the last five years? (indicate the test results below)	☐	☐	☐	☐
13. ever made a claim or received a pension, payments or compensation benefits for an accident or sickness?	☐	☐	☐	☐
14. ever had an application for insurance declined, postponed or modified in any way?	☐	☐	☐	☐
15. been involved in the operation of an aircraft, or participated in hazardous activities such as motorized racing, hang gliding, parachuting, skin or scuba diving? (If "yes", circle the appropriate activity)	☐	☐	☐	☐
16. smoked cigarettes in the past 12 months?	☐	☐	☐	☐
17. have your parents, brothers or sisters ever had cancer, diabetes, heart or kidney disease or any hereditary disorder? (If "yes", provide complete details)	☐	☐	☐	☐
18. had any change in weight in the past year? (If "yes", indicate who)	☐	☐	☐	☐

Amount gained: _____ Amount lost: _____ Reason: _____

Complete question #19 only if application is for Disabled Dependent over age 22:

19. Nature of Disability if Disabled Dependent _____

Age Disability Commenced _____

Is the disabled dependent "gainfully" employed? (gainful employment is defined as any work for remuneration or profit which allows the dependent complete independence from any other person, or institution for livelihood or support) ☐ Yes ☐ No

(please attach any medical information available to support your claim)

M5995(330785)-3/12

Next

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 0F 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, ONTARIO M5G 1R7, TELEPHONE 416.597.0590.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, 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.

Next

DETAILS

QUES. NO.	NAME	TEST, INJURY, ILLNESS, OPERATION OR COMPLICATION	DATE OF ONSET	DATE OF RECOVERY	FULL DETAILS (INCLUDING DOCTORS' NAMES AND ADDRESSES)

AUTHORIZATION AND DECLARATIONS

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the Medical Information Bureau, 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;

I certify or confirm that:

- I have read and agree with the Important Notice describing the procedures of the Medical Information Bureau;
- 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.

Employee Signature _____ Date Signed _____
(if applying for disabled dependent coverage)

Spouse Signature _____ Date Signed _____

Clear