THE Great-West Life ASSURANCE COMPANY

PART A

GROUP LIFE INSURANCE
WAIVER OF PREMIUM BENEFIT APPLICATION
EMPLOYEE'S STATEMENT

Instructions to Employee:

1. You complete Part A, and ask your physician to complete Part B.
2. After Part B is completed, insert it into an envelope and seal it (for confidentiality).
3. Securely attach Part A to the sealed envelope containing Part B.
4. Forward both Parts A and B together to: Civil Service Superannuation Board
1200-444 St Mary Ave.
Winnipeg, MB R3C 3T1

Group Plan Number **330780** Division Number ________ Employee Number ________________

Civil Service Superannuation Board Personal Identification Number ____________________________

NOTICE OF CLAIM

Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

Your Name: First ____________________ Initial __________ Last ____________________

Address: Street & Number ____

P.O. Box ____

City ____________________ Province ______________ Postal Code __________

Telephone: Home (______) ____________________

Cell (______) ____________________

2. Date of birth: Year ____________ Month ____________ Day ____________

Claim Information

1. If disability is due to an accident, give date accident occurred: Year ______ Month ________ Day ________

Where and how did it occur? ____

Was the accident work-related? ☐ Yes ☐ No

2. From what date has your disability continuously prevented you from performing your regular work?

Year ____________ Month ____________ Day ____________

3. Have you performed any **other** work since that date? ☐ Yes ☐ No

If yes, describe ____

____

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4. Are you able to do any other work? ☐ Yes ☐ No

If yes, describe ____

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Education / Training / Experience

High School ☐ Yes ☐ No Grade Completed __________ Date Completed __________________

College or University ☐ Yes ☐ No Years Completed __________ Date Completed __________________

Certificate / Diploma / Degree attained ____

Other Education such as Technical or Trade School, Apprenticeship, etc. ☐ Yes ☐ No

What did you study? ______________________________ Date Completed __________________

Certificate / Diploma / Degree attained ____

Please describe any other special training you have received or skills you have developed, including dates completed where applicable. ____

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____

Please name all other jobs you have had with your present employer and the number of years you worked in each. Include dates.

Job	Number of years from	to
	–	
	–	
	–	

List all other jobs you have performed in the last 10 years and the number of years worked in each. Include part-time and self-employment.

Job	Number of years from	to
	–	
	–	
	–	

Are you now working or volunteering in any capacity, either at home or outside? If so, please describe.

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Financial

1. Are you receiving self employment or any other income? ☐ Yes ☐ No
   If yes, provide $ ____________________ per week OR $ ____________________ per month.
2. Do you have Individual Disability, Creditor, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life, or London Life? ☐ Yes ____________________ Plan Number ☐ No

   For the duration of your claim for benefits, it is your responsibility to notify CSSB of:

   - **any work performed, whether or not you have received a wage or remuneration, or**
   - **any employment income paid to you or any other person or party as a result of work performed by you.**

   CSSB in turn will provide this information to Great-West Life.

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 a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. 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 to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan. 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.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations 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 Statement concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

Print Name ____________________ Signature ____________________

Date ____________________ Telephone Number ____________________