THE Great-West Life ASSURANCE COMPANY

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

Group Plan Number: 330780 Division Number: _____

Employee Number: _____

Employee Identification

Name: Last _____ First _____ Initial _____

Date of Birth: _____ ☐ Male ☐ Female

Address: Street & Number: _____

City _____ Province _____ Postal Code _____

Home Telephone Number: (_____) _____

Cell Number: (_____) _____

Employment Information

Employment Start Date: _____ Date First Insured: _____

Occupation Prior to Disability **(a job description is required, please attach to application)**: _____

_____

Last Physical Day at Work: _____ Sick Leave Expiry Date*: _____

***field requires either sick leave expiry date or; if sick leave has not expired, number of sick leave days left unused.**

If Employee Terminated / Retired Due to Ill Health, Date Insurance Provided to, if applicable: _____

Has Employee Returned to Work? ☐ Yes ☐ No If yes, Date Returned: _____

Insurance Annual Salary as of Last Day on Payroll: $ _____ Class of Insurance: _____

Amount of Life Insurance as of Last Day on Payroll: $ _____ Dependent Units, if applicable: _____

Declaration

I hereby declare that the answers to the above questions are accurate and complete.

Employer / Department Name: _____

Name (please print): _____

Authorized Signature: _____ Title: _____

Date: _____ Telephone Number: _____

Return to:

Civil Service Superannuation Board
1200-444 St. Mary Avenue
Winnipeg, MB R3C 3T1

Clear