canada life™

EVIDENCE OF INSURABILITY

Coverage Detail

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

- Sections 1-3: To be completed first by the Plan Administrator. Retain a copy of the completed section for your files.
- Section 3: To be reviewed, signed and dated by the employee; including completion of the smoking and beneficiary declarations (if applicable).
- Sections 4-5: To be completed by the employee/spouse and submitted to Canada Life. **Retain a copy for your files.**
- Employee to send the form directly to Canada Life via mail/email.

1 Employee's information (completed by plan administrator)

Name of group policyholder (Employer)	Policy no.	Division no.	Benefit class

Employee last name	First name	Middle initial	ID no.

Is the employee currently actively at work?	If no, please indicate reason and Expected Return to Work Date.	
☐ Yes ☐ No	☐ Maternity/Paternity ☐ On Claim / Personal LOA / Other	MMM/DD/YYYY

Date of employment MMM/DD/YYYY	Annual earnings	Plan administrator's name	Plan administrator's Phone No. XXX-XXX-XXXX	Plan administrator's email address

Plan administrator's authorization	Date authorized MMM/DD/YYYY
☐ I hereby certify that the information on this Coverage Detail form is accurate.	

2 Reason for application (completed by plan administrator)

☐ New Enrolment

☐ *Late Applicant (Eligibility Period Expired)..... Complete section 3 (A)..... ***Application for Group Coverage, or Group Coverage Change Form, must be included.**

☐ Increase Coverage ..... Complete applicable portion of section 3 (B), (C) or (D)

☐ Annual Enrolment - Effective Date: MMM/DD/YYYY Complete applicable portion of section 3 (B), (C) or (D)

3 Benefits requested (completed by plan administrator)

A For Late Applicants

	Employee	Spouse	Children
Basic Life	☐	☐	☐
Healthcare	☐	☐	☐
*Dental	☐	☐	☐
Short Term Disability	☐		
Long Term Disability	☐		

***Dental Restrictions may apply. Refer to employee booklet or contract.**

B Excess Coverage

		Current amount	New total amount applied for
Life	☐ Basic ☐ Supplemental		
Short Term Disability			
Long Term Disability			

M5995-12/20

3 Benefits requested (continued)

C Optional Flex Benefits

	Current: % of earnings	Current amount ($)	New option: % of earnings	New amount ($)
Short Term Disability				
Long Term Disability				

D Optional Coverage

New employees and their spouses may elect, without evidence, within 31 days of eligibility, Optional Critical Illness Insurance up to the Non-Evidence Maximum (NEM) amount for their group plan. The NEM must be confirmed by plan administrator. (Step 3 below).

Applicant	(1) Current Amount	(2) New total amount applied for	(3) Amount available without evidence (NEM) (confirm with plan administrator)	(4) Amount applied for with medical evidence (Steps 2-3)	If plan is % of salary, total % applied for:
Employee					
Optional Life					
Optional Critical Illness					
Spouse					
Optional Life					
Optional Critical Illness					
Child					
Optional Life					

****Medical questionnaire not required if applying for the NEM amount.** Overall maximum for optional critical illness insurance is $250,000.

Smoking Declaration (completed by member)

In the **past 12 months**, have you used any form of tobacco, nicotine products or nicotine substitute? *This includes: cigarettes, e-cigarettes/vaporizers, cigarillos, pipe, cigars, chewing tobacco, nicotine patch and/or gum, hookah/shisha, or such products in any other form.*

EMPLOYEE: ☐ Yes ☐ No **SPOUSE:** ☐ Yes ☐ No

Optional Life Beneficiary Designation (completed by member)

This section must be completed to designate a beneficiary for your life benefits, if applicable. **The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed. Please print clearly, in INK.**

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

First Name	Last Name	Middle Initial	Date of birth MMM/DD/YYYY	Percent allocated	Relationship to employee

To be divided as follows: ☐ As per the percentage indicated above, or ☐ In equal shares to the survivor(s)

- The Beneficiary for the spousal or child coverage shall be the employee if living, otherwise the estate. I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

NOTE: Where Quebec law applies: and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable", below.

I hereby make the above beneficiary designation: ☐ Revocable, I may change this beneficiary at any time

- An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.

Plan Member's Signature

Signature	Date MMM/DD/YYYY

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- Employee to send the form directly to Canada Life via mail/email.

4 Member and dependant details (completed by the member)

Employee information

Name of group policyholder (Employer) | Policy no.

Employee last name | First name | Middle initial | Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other | Date of birth MMM/DD/YYYY

Home mailing address | Street | City | Province | Postal Code

Email address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Mobile phone number XXX-XXX-XXXX | Alternate contact number / extension XXX-XXX-XXXX XXXX

NOTE: If you provide your mobile number, we may use it to communicate messages with you about this application.

Spouse information (if applicable) - *only required if you are applying for dependant coverage.*

Spouse last name | First name | Middle initial | Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other | Date of birth MMM/DD/YYYY

Home mailing address | Street | City | Province | Postal Code

Email address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Mobile phone number XXX-XXX-XXXX | Alternate contact number / extension XXX-XXX-XXXX XXXX

NOTE: If you provide your mobile number, we may use it to communicate messages with you about this application.

Child Information (if applicable) - *only required if you are applying for dependant coverage.*

	Child Last Name	Child First Name	Gender	Date of Birth
Child (1)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY
Child (2)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY
Child (3)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY
Child (4)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY

5 Personal Medical History and Lifestyle Information

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 done. However, you must tell us if you're having treatment for, or experiencing symptoms of a genetic condition. You will be asked to provide us full information about your family history, including all genetic conditions.

If you answer 'yes' to any of the health questions, Canada Life will require more information to assess your application. In this case, a representative of Canada Life will contact you to complete a health assessment.

EE = Employee **SP** = Spouse **CH** = Child(ren)

1. What is your **current** height and weight?
   We need an accurate current measure, not an estimate.

	Height	Weight
EE	_____ ☐ feet/inches ☐ m/cm	_____ ☐ pounds ☐ kg
SP	_____ ☐ feet/inches ☐ m/cm	_____ ☐ pounds ☐ kg

2. Have you **ever** been treated for, or had any known indication of:
   - Conditions or issues affecting your heart, blood, circulation, high blood pressure, high cholesterol, immune system such as HIV or AIDS, breathing such as tuberculosis, emphysema, COPD, sleep apnea or asthma (excluding non-smokers with mild/seasonal asthma), or any other lung or respiratory problems
   - Conditions, issues or injuries affecting your brain or nervous system, such as aneurysm, stroke, concussion, epilepsy, seizures, numbness, multiple sclerosis, ALS, Huntington's, Parkinson's
   - Conditions or issues affecting your esophagus, stomach, pancreas, liver, gall bladder or bile duct, intestine, colon, bladder (excluding resolved bladder infections), kidneys, prostate or reproductive system, such as Crohn's disease or colitis
   - Loss of speech, loss of sight, loss of hearing or any condition affecting your eyes or ears
     You do not need to tell us about ear tubes, vision corrected with eye glasses/contact lenses or minor infections which have completely resolved
   - Any form of cancer, tumor (benign or malignant), diabetes, abnormal blood sugar or sugar in the urine, hepatitis, or lupus
   - Any bone, joint, muscle or skin condition, such as arthritis, psoriasis, ankylosing spondylitis or back pain, that **ever** require(d) medication or treatment
     You do not need to tell us about a muscle or bone injury, or minor infection, from which you have completely recovered
   - Any conditions or issues affecting your behaviour or mental health, such as anorexia nervosa, bulimia, depression, bipolar disorder, self-harm, schizophrenia, stress, or anxiety, requiring medication, treatment or time off work/school

	Yes	No
EE	☐	☐
SP	☐	☐
CH	☐	☐

3. Other than for a regularly scheduled physical or routine check-up, are you **currently** undergoing or awaiting any consultations or exams, or recommended, scheduled or pending tests or test results, treatment or procedures, including surgery, for any health issues, symptoms or conditions?
   Other than an uncomplicated pregnancy, vasectomy, dental surgery, cosmetic surgery or a muscle/joint or bone injury which you have fully recovered from, this includes (but is not limited to): biopsies, ECGs, x-rays, CT scans, MRIs, blood tests, ultrasounds, endoscopies, colonoscopies, pap tests, mammograms.

	Yes	No
EE	☐	☐
SP	☐	☐
CH	☐	☐

4. Do any of your immediate biological family members (parents, siblings, children), suffer or have suffered from any of the following:
   - Alzheimer's Disease
   - Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
   - Cancer
   - Cardiomyopathy
   - Dementia
   - Diabetes
   - Heart Disease
   - Huntington's chorea
   - Motor Neuron disease
   - Multiple Sclerosis
   - Parkinson's Disease
   - Polycystic Kidney disease
   - Retinitis Pigmentosa
   - Stroke
   - and/or any other **hereditary** medical condition

	Yes	No
EE	☐	☐
SP	☐	☐
CH	☐	☐

5. In the **past 12 months**, have you used any form of tobacco, nicotine products or nicotine substitute?
   This includes: cigarettes, e-cigarettes/vaporizers, cigarillos, pipe, cigars, chewing tobacco, nicotine patch and/or gum, hookah/shisha, or such products in any other form.

	Yes	No
EE	☐	☐
SP	☐	☐

6. In the **past 10 years**, have you used any drug(s) or narcotic(s) **(including cannabis)**, or had any issues with alcohol abuse including being advised to stop or reduce your consumption?

	Yes	No
EE	☐	☐
SP	☐	☐
CH	☐	☐

7. In the **past 2 years**, have you engaged in any high-risk activities, or do you plan to do so in the **next 12 months**?
   Examples include: aviation (pilot or crew member), boxing, ballooning, bungee jumping, hang gliding, heli skiing/snowboarding, motorized racing (car, motorcycle, boat, snowmobile, etc.), rock/ice climbing, scuba diving, skydiving or other parachute jumping, or white water rafting.

	Yes	No
EE	☐	☐
SP	☐	☐
CH	☐	☐

Notice About MIB Inc.

IMPORTANT NOTICE

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to the MIB Inc., 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.

Canada 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 of 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:

MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Tel 781-751-6000

Protecting Your Personal Information

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada 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 Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.*The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.*

If you want to know more:

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Authorization and Declarations

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan;
- Canada Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application;
- Canada Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Canada Life to communicate with me about this application, with electronic messages, using either the mobile number or the email address I have provided;
- My plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I am actively at work on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- 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 Canada Life must be reported to Canada 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 Canada Life, I am not insurable for all or part of that benefit.

For Quebec Applicants: I request that all communication and documents be in English.
Je demande à ce que toutes les communications et tous les documents soient en anglais.

Employee Signature _____ Date Signed _____ MMM/DD/YYYY

Spouse Signature _____ Date Signed _____ MMM/DD/YYYY

Mailing Address

The Canada Life Assurance Company
Group Medical Underwriting
PO Box 6000
Winnipeg MB R3C 3A5

Email: groupmed@canadalife.com
Telecommunications Relay Service: 1.800.855.0511
(available for the hearing impaired)