Privileged SELECTION™

GROUP TERM LIFE INSURANCE

Coughlin & Associates Ltd. | PO BOX 3517, Station C | Ottawa, ON K1Y 4H5 | tel: 613-231-2266 | fax: 613-231-2345 | 1-888-613-1234 | www.coughlin.ca

Application for coverage

Print Form

THE Great-West Life ASSURANCE COMPANY

The following are the monthly premiums for each $10,000 unit of coverage. The maximum coverage available is $500,000 for employees and $500,000 for spouses. Premiums are based on your age, gender and smoking habits.

Example: The monthly premium for a 38-year-old female non-smoker requiring $100,000 of coverage (10 x $10,000) would be $6.00 (10 X $0.60). The monthly premium for a male non-smoker the same age would be $7.00 (10 X $0.70).

Age	Male non-smoker	Male smoker	Female non-smoker	Female smoker
To age 34	$0.60	$1.00	$0.50	$0.70
35-39	0.70	1.30	0.60	1.00
40-44	1.00	2.10	0.90	1.60
45-49	1.90	3.90	1.60	2.70
50-54	3.30	6.50	2.70	4.40
55-59	6.10	11.20	4.30	6.70
60-64	8.60	15.10	5.70	8.40
65-69	11.70	19.60	7.90	10.80

MEMBER INFORMATION

Full name (first, initial, last): _____

Address: _____ Email address: _____

City: _____ Province: _____ Postal code: _____

Date of birth (YYYY/MM/DD): _____ Home phone number: _____ Personal identification #: _____

Gender: ☐ Male ☐ Female Smoked in past 12 months? ☐ Yes ☐ No Language: ☐ English ☐ French

Occupation: _____ Work phone number: _____ Ext.: _____

Your height: _____ ☐ ft/in. ☐ cm Your weight: _____ ☐ lbs. ☐ kg

Amount of life insurance coverage requested: _____

OFFICE USE ONLY

ID # _____

Division # _____

SPOUSAL INFORMATION (IF APPLICABLE)

Full name (first, initial, last): _____

Date of birth (YYYY/MM/DD): _____ Gender: ☐ Male ☐ Female Smoked in past 12 months? ☐ Yes ☐ No

Spouse's height: _____ ☐ ft/in. ☐ cm Spouse's weight: _____ ☐ lbs. ☐ kg

Amount of life insurance coverage requested: _____

YOUR REVOCABLE BENEFICIARY

Name(s): _____ Relationship: _____

_____ _____

_____ _____

The beneficiary for the spouse's coverage will be the employee, if living, otherwise the employee's estate.

Where Quebec law applies, a spouse beneficiary is irrevocable (cannot be changed) unless you make the designation revocable by checking here: ☐ Revocable

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Medical questionnaire

Print Form

MEDICAL QUESTIONNAIRE

PART 1	MEMBER	SPOUSE
(a) Within the past two years, have you received medical or surgical attention because of illness or injury?	Yes ☐ No ☐	Yes ☐ No ☐
(b) During the past five years, have you had X-rays, electrocardiograms, blood or other special tests, for other than regular medical check-ups?	Yes ☐ No ☐	Yes ☐ No ☐
(c) Have you ever had or been told you have heart trouble, high blood pressure, stroke, any brain or nervous system disorder, any blood disorder, colitis or other intestinal disorder, liver disorder, ulcers, diabetes, tumors, any kidney or urinary tract disorder, acquired immune deficiency syndrome (AIDS) or tested positive for HIV?	Yes ☐ No ☐	Yes ☐ No ☐
PART 2 – HAVE YOU OR YOUR SPOUSE:		
(a) any knowledge of any condition now existing that might require you to enter a hospital or undergo any surgical, medical or psychiatric treatment?	Yes ☐ No ☐	Yes ☐ No ☐
(b) ever applied for life or health insurance that has been declined, rated or modified in any way?	Yes ☐ No ☐	Yes ☐ No ☐
(c) been involved in the operation of an aircraft, or do you participate in any hazardous activity(ies) such as (circle activity/ies) scuba diving, skydiving, hang gliding, auto or motorcycle racing? If other, please specify	Yes ☐ No ☐	Yes ☐ No ☐
(d) any reason to believe you are not now in first class health and free from all symptoms of disease or impairment?	Yes ☐ No ☐	Yes ☐ No ☐
(e) any immediate family member with a history of diabetes, cancer, high blood pressure, heart or kidney disease?	Yes ☐ No ☐	Yes ☐ No ☐

If "yes" to any answer, provide details in the space below including specific test, injury, illness or operation and doctors' names and addresses.

Member:

Spouse:

AUTHORIZATION

The foregoing information will be used by Great-West Life to determine your insurability and to provide benefits under this plan.

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 have retained a copy of this application.

I understand that this coverage does not take effect until approved by Great-West Life.

For the purposes of this insurance, I permit any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person that has records or knowledge of me or my health to give any such information to the Great-West Life Assurance Company, or its reinsurer(s). A photocopy of this authorization will be as valid as the original.

Date (YYYY/MM/DD)	You must print THEN sign this form Member signature	Date (YYYY/MM/DD)	You must print THEN sign this form Spouse signature (for spouse's coverage)