

APPLICATION FOR DEPENDENT CHILDREN LIFE INSURANCE STATEMENT OF DEPENDENT'S HEALTH

1.

Eligible Dependents	Relationship	Date of Birth	Height (in/cm)	Weight (lbs/kg)

2. Have any of your dependents received treatment for, or had any medication prescribed for any ailment during the past 12 months? If yes, please give details below. Yes No

3. Have any of your dependents consulted or received treatment from a physician, physiotherapist, masseur, osteopath or chiropractor during the past 12 months? If yes, please give details below. Yes No

4. Are all of your dependents now in good physical and mental health and free from any physical defect or any symptoms of illness or disease? If no, please give details below. Yes No

Name of Dependent	Age	Nature of Illness

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organizations Institution or person, that has any medical records or medical knowledge of me or any of my dependents, who are proposed for insurance, to give the Great West Life Assurance Company or its reinsurer(s) any such information for the purpose of determining eligibility for the insurance applied for. A photographic copy of this authorization shall be as valid as the original.

I declare the above statements are true and complete and shall form part of the application for insurance.

Date _____ Applicant Name _____ Signature _____
(please print)

Address _____ City _____ Postal Code _____