

**PLEASE PRINT (Each Individual applying for insurance must complete a separate form.)**

A. This is a:  First Application  Application for additional insurance under Certificate No. \_\_\_\_\_  Request for transfer of insurance from Group \_\_\_\_\_

B. (1) Application is for:  Member  Member Spouse  Student  Student Spouse  
 (2) Are you a Member / Student of the Institute: (check institute)  Yes  BC  AB  MB  SKw  No  
 (3) If application is for insurance on a spouse, please provide name of Member / Student: \_\_\_\_\_  
 Note: You must be a member or student of a participating institute or the spouse of such member/student, to maintain eligibility for this insurance.

C. Complete if this is a first application. Insurance applying for: Amount of Insurance

Term Life	\$ _____
Accidental Death and Dismemberment	\$ _____
Member Long Term Disability Waiting Period (Days): <input type="checkbox"/> 30 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> 30	
<input type="checkbox"/> Add optional indexing to 10%	\$ _____
Member Office Overhead	\$ _____
Dependent children term life, AD&D: <input type="checkbox"/> Yes (application on website)	
Critical Illness	\$ _____

D. Complete if application is for additional insurance or if a request for transfer.

	Present Amount of Insurance	Additional Amount Applying for	Total Amount of Insurance
Term Life	\$ _____	\$ _____	\$ _____
Accidental Death or Dismemberment	\$ _____	\$ _____	\$ _____
Member Long Term Disability	\$ _____	\$ _____	\$ _____
Waiting Period (Days) <input type="checkbox"/> 30 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> 365 <input type="checkbox"/> Add optional indexing to 10%			
Member Office Overhead	\$ _____	\$ _____	\$ _____
Critical Illness	\$ _____	\$ _____	\$ _____

E. To be completed in full. Please Print

(1) a) Name of Applicant \_\_\_\_\_  
 b) Residence Address \_\_\_\_\_  

LAST
FIRST
SECOND
  
 c) Name of Employer \_\_\_\_\_  
 d) Employer Address \_\_\_\_\_  

CITY
PROVINCE
POSTAL CODE
  
 e) Your Occupation \_\_\_\_\_ Average Monthly Earnings \$ \_\_\_\_\_  
 f) Residence Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
 g) Address to which correspondence is to be forwarded:  Residence  Business  Email \_\_\_\_\_

(2) Birthday \_\_\_\_\_ (3)  Male  Female  
MONTH / DAY / YEAR

(4) Beneficiary Designation (for Term Life or Accidental Death)  
 I hereby revoke all previous beneficiary designations and designate the following beneficiary(ies):

Beneficiary's name(s)	% Allocated	Relationship to Applicant						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">LAST NAME</td> <td style="width: 33%;">FIRST NAME</td> <td style="width: 34%;">MIDDLE INITIAL</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	LAST NAME	FIRST NAME	MIDDLE INITIAL	_____	_____	_____	_____	_____
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LAST NAME	FIRST NAME	MIDDLE INITIAL						
_____	_____	_____						

To be divided  As per the percentages indicated above or,  In equal shares to the survivors(s)  
 You may change this beneficiary designation at any time by notifying CAIPW. If designating a beneficiary who is a minor or who lacks legal capacity, you must appoint a trustee/administrator. Please contact CAIPW.

- (5) Are you now actively engaged in your occupation on a full-time basis?  Yes  No
- (6) Do you have insurance coverage in force or pending?  Yes  No  
If yes, please give details: \_\_\_\_\_
- (7) Do you intend to travel, reside or work outside of North America for over 2 months within the next 2 years?  Yes  No  
If yes, please give details: \_\_\_\_\_

## MEDICAL QUESTIONNAIRE

Height \_\_\_\_\_ in/cm Weight \_\_\_\_\_ lbs/kg

### IF ANSWER IS YES TO ANY OF THE QUESTIONS BELOW, GIVE FULL DETAILS:

All questions should be fully completed to avoid delays in the assessment. Use the Details section below to explain all questions answered "Yes" (if more space is required, attach another sheet).

Have you ever been tested for, treated for, or told you had:

1. abnormal blood pressure, ECG, chest pain, angina, heart murmur, heart attack, phlebitis, elevated cholesterol, or any other disease or disorder of the heart or blood vessels?  Yes  No
2. ulcers, jaundice, chronic diarrhea, intestinal bleeding, pancreatitis, hepatitis, liver disease, or any other disease of the stomach, intestines, rectum or liver?  Yes  No
3. asthma, bronchitis, shortness of breath, emphysema, tuberculosis or any other respiratory disease?  Yes  No
4. abnormal urine, venereal disease, or any disease of the kidneys, bladder, prostate or reproductive organs or breasts?  Yes  No
5. arthritis, back pain, fibromyalgia, systemic lupus erythematosus, or any other disease, or disorder of the joints, bones or muscles?  Yes  No
6. epilepsy, paralysis, stroke, Transient Ischemic attacks (TIA), recurrent headaches, dizziness, aneurysm, multiple sclerosis, tingling of limbs, Alzheimer's, Parkinson's or any other disease or disorder of the brain or nervous system?  Yes  No
7. anxiety, stress, depression, fatigue or burnout or any other mental illness?  Yes  No
8. diabetes, thyroid or any other glandular disease?  Yes  No
9. cancer, cyst, tumor, polyp or other growth, skin lesion or any form of malignant disease?  Yes  No
10. anemia, leukemia, or any other disease of the blood or lymph glands?  Yes  No
11. loss of speech or any disease or disorder of the eyes, ears, nose or throat?  Yes  No
12. AIDS or other disorder of the immune system, or test results indicating exposure of the AIDS virus (HIV)?  Yes  No
13. ever been in a hospital, sanitarium or other institution for treatment or observation?  Yes  No
14. any reason to believe you will require medical or surgical treatment during the next 12 months?  Yes  No
15. x-rays, electrocardiograms, blood or other special tests, for other than regular medical checkups in the last five years? (indicate the test results below)  Yes  No
16. in the past 5 years, have you used marijuana, cocaine, narcotics, hallucinogenic or other habit-forming drugs?  Yes  No
17. a) indicate type and average weekly consumption of alcohol. \_\_\_\_\_  Yes  
b) have you ever been advised to reduce your intake or been treated for excessive use of alcohol?  No
18. have you had any illness or injury within the past two years which resulted in a continuous absence from work of 10 days or more? If "Yes", state reason and duration of absence in Details section.  Yes  No
19. have you taken medication or been treated for or told that you have any physical impairment, condition, disease or disorder not stated in this questionnaire?  Yes  No
20. Please give date and reason physician was last consulted. \_\_\_\_\_
21. are you aware of any symptoms or complaints regarding your health for which you had not consulted a physician?  Yes  No
22. ever made a claim or received pension, payments or compensation benefits for an accident or sickness?  Yes  No
23. ever had an application for insurance declined, postponed or modified in any way?  Yes  No
24. been involved in the operation of an aircraft, or participated in hazardous activities such as motorized racing, hang gliding, parachuting, skin or scuba diving? (If "Yes", circle the appropriate sport)  Yes  No
25. have you used tobacco products within the last year, including nicotine products/patches?  Yes  No  
If "Yes", give details of type and amount \_\_\_\_\_
26. had any change in weight in the past year?  Yes  No  
Amount gained: \_\_\_\_\_ Amount lost: \_\_\_\_\_ Reason: \_\_\_\_\_

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QUES. NO.	TEST, INJURY, ILLNESS OPERATION OR COMPLICATION	DATE OF		FULL DETAILS (INCLUDING DOCTORS NAMES AND ADDRESSES)
		ONSET	RECOVERY	

**FAMILY HISTORY**

Has any parent, brother or sister ever had cancer, or tumors of the breast and or colon, heart disease, stroke, high blood pressure, diabetes, polycystic or other kidney disease, Huntington's chorea, Alzheimer's disease, multiple sclerosis or any other inherited disease?

Yes  No

RELATIONSHIP TO APPLICANT	CONDITION	AGE OF ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH

**NOTICE ABOUT MEDICAL INFORMATION BUREAU**

IMPORTANT NOTICE: Your personal information will be treated as confidential. Great West Life or its reinsurer(s) may, however, make a brief report to the Medical Information Bureau, 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.

Great West Life or it's 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: Suite 501, 330 University Ave., Toronto, Ontario M5G 1R7. Telephone (416) 597-0590

**PROTECTING YOUR PERSONAL INFORMATION**

CAIPW and Great West Life recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of CAIPW and/or Great West Life. We limit access to personal information in your file to CAIPW and/or Great West Life staff or persons authorized by CAIPW and/or Great West Life who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your insurability and to administer the group benefits plan.

**AUTHORIZATION AND DECLARATION**

**I authorize:**

- Great West Life, any healthcare provider, CAIPW, other insurance companies or reinsurance companies, the Medical Information Bureau, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great West Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan.
- Great West Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application.

**I certify or confirm that:**

- I am actively at work (including homemaking) on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the Medical Information Bureau;
- I have retained a copy of this application;
- 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 date Great West Life makes a decision must be reported to Great West 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 coverage for all or part of the benefit if, in the opinion of Great West Life, I am not insurable for all or part of that benefit.

**Applicant** Signature \_\_\_\_\_ **Date** Signed \_\_\_\_\_

**Witness** Signature \_\_\_\_\_ **Date** Signed \_\_\_\_\_

**TOTAL PREMIUM DUE**

Calculate premiums for benefits applied for the number of months to next April 1 (exclude present month).  
Age for the premium calculation means your age at the beginning of the policy year (April 1.)

Total Premiums \$ \_\_\_\_\_ Pro-rated premium due with this application. Make cheques payable to: CA Insurance Plans West

Term Life benefits and Disability benefits underwritten by GREAT WEST LIFE ASSURANCE COMPANY. Accidental Death & Dismemberment benefit underwritten by INDUSTRIAL ALLIANCE PACIFIC LIFE INSURANCE COMPANY.

MAIL YOUR COMPLETED APPLICATION AND PREMIUMS TO THE PLAN ADMINISTRATOR:

