canada life™

EVIDENCE OF INSURABILITY
Late Applicant Benefit Requests

Coverage detail

Instructions:

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

- Coverage detail - To be completed first by the plan administrator.
- Member and dependent details; Medical and lifestyle questionnaire; Authorization and declarations - To be completed by the employee/spouse.
- Optional life beneficiary designation - To be completed by the employee (if applicable).

If completing the form electronically via the DocuSign eSignature service, your form will be automatically received by Canada Life when you complete the digital process. If printing and completing the form manually, please print all responses clearly and complete in INK only (blue or black).

Group plan and employee information (to be completed by plan administrator)

Plan adminstrator's email address _____

Name of group policyholder (Employer) _____

Employee last name _____

Employee first name _____

Employee ID _____

Plan member province of employment _____

Plan member province of residence _____

Policy numbers(s) _____

Division number _____

Benefit class _____

Date of employment (Hire date) _____

Annual earnings _____

What is the employee's current work status? ☐ Active at work ☐ Maternity / Paternity ☐ On Claim / Personal LOA / Other

Group benefit request (to be completed by plan administrator)

Late applicants

Use this section to indicate the group benefit coverage you are requesting and for which you may be late to apply.

	Employee	Spouse	Child
Basic life	☐	☐	☐
Healthcare	☐	☐	☐
Dental*	☐	☐	☐
Critical illness	☐	☐	☐
Short term disability	☐		
Long term disability	☐		

* Late applicant dental restrictions may apply. Refer to employee booklet or contract.

Optional coverage

If applicable, use this section to apply for additional/optional coverage.

	Employee			Spouse			Child		
	Current amount ($) * or Option #	New total amount ($) or Option # or % of salary	NEM (Amount available without evidence)	Current amount ($) * or Option #	New total amount ($) or Option # or % of salary	NEM (Amount available without evidence)	Current amount ($) * or Option #	New total amount ($) or Option # or % of salary	NEM (Amount available without evidence)
Optional life									
Optional critical illness									

* If applying for optional coverage for the first time, the current amount is not applicable, or equal to $0.
** Medical Questionnaire not required if applying for the NEM amount only.

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Member and spouse information

Name of group policyholder (Employer) _____ Policy numbers(s) _____

Employee

Last name _____ First name _____ Middle name or initial _____

Date of birth _____ Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Home mailing address _____ Unit or Suite # (If applicable) _____

City _____ Province _____ Postal code _____

Email address _____ Best contact number (mobile preferred) _____

Spouse

Last name _____ First name _____ Middle name or initial _____

Date of birth _____ Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Email address _____ Best contact number (mobile preferred) _____

What group benefits coverage does your spouse have through their employer?
Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

	HEALTHCARE				DENTALCARE				VISIONCARE			
	Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Note: If you provide your email address or mobile number, we may use it to communicate with you about this application.

Dependant information (Additional information may be added on page 7)

Last name	First name	Date of birth	Gender	Full time student	Disabled dependant
			☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
			☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
			☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐
			☐ Male ☐ Female ☐ Undisclosed ☐ Other	☐	☐

This section must be completed if you are adding a dependant

Reason: ☐ Birth of child ☐ Divorce ☐ Marriage ☐ Cohabitation – Date of marriage/cohabitation: _____

☐ Other (please specify) _____

Date of event/reason list above: _____

Addition of group health and/or dental benefits

You may apply to be enrolled for group coverage if your spouse has lost group benefits coverage through their employer.

Effective date of loss of coverage through spousal plan: _____

Indicate the benefit(s) no longer covered under the spousal plan: ☐ Healthcare ☐ Dentalcare

Refusal of benefits

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but I decline to participate in:

Healthcare for ☐ myself and my dependants ☐ my dependants only
Dentalcare for ☐ myself and my dependants ☐ my dependants only

Spousal insurer's name: _____ Plan number: _____

Effective date of change: _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependants may be required to provide proof of insurability acceptable to Canada Life to be covered. If you are approved, coverage for dental benefits may be limited. Please see your plan administrator for details.

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Primary beneficiary designation

This section must be completed to designate a beneficiary for your life benefits, if applicable. **An original or copy of this form will be required for a life claim. Crossed out beneficiary designations must be initialed.**

I hereby revoke all previous beneficiary designations for this optional life benefit and designate the following as beneficiary(ies).

First name	Last name	Date of birth	Percent allocated	Relationship to employee

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

You may change this beneficiary designation at any time upon notice to Canada Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form M6348.

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 designation at any time

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Canada Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. **Before designating a trust, you should seek legal advice.**

Contingent beneficiary designation

This section must be completed to designate a beneficiary for your life benefits, if applicable. **An original or copy of this form will be required for a life claim. Crossed out beneficiary designations must be initialed.**

I hereby revoke all previous beneficiary designations for this optional life benefit and designate the following as beneficiary(ies).

First name	Last name	Date of birth	Percent allocated	Relationship to employee

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

You may change this beneficiary designation at any time upon notice to Canada Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form M6348.

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 designation at any time

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Canada Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. **Before designating a trust, you should seek legal advice.**

Trustee appointment

You may wish to appoint a trustee/administrator by completing this section.

DO NOT COMPLETE THIS SECTION IF YOU ARE A QUEBEC RESIDENT

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing this form. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

Do not complete this section if you have made another trustee/administrator appointment.

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release The Canada Life Assurance Company from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in trust.

Trustee last name: _____ First name: _____

Relationship to plan member: _____

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Optional life beneficiary designation

This section must be completed to designate a beneficiary for your optional life benefits, if applicable. **An original or copy 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 for this optional life benefit and designate the following as beneficiary(ies).

First name	Last name	Date of birth	Percent allocated	Relationship to employee

Spousal or child coverage terminates when the employee is no longer covered under the group benefits plan. The beneficiary for the spousal or child coverage shall be the employee if living, otherwise the employee's estate in the event of simultaneous death.

You may change this beneficiary designation at any time upon notice to Canada Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form M6348.

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 designation at any time

Signature _____ Date signed _____

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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:
   - Blindness
   - Cancer
   - Cardiomyopathy
   - Dementia (including Alzheimer's disease)
   - Diabetes
   - Heart Disease
   - Huntington's chorea
   - Motor Neuron disease (including ALS or Lou Gehrig's disease)
   - Multiple Sclerosis
   - Parkinson's Disease
   - Polycystic Kidney disease (or any kidney failure requiring dialysis)
   - 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 recreational drug(s) or narcotic(s) (including cannabis), or had any issues with excessive alcohol use 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	☐	☐

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Notice about MIB, LLC.

IMPORTANT NOTICE

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to MIB, LLC., 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, LLC. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Tel 781-751-6000

Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your online account or by submitting a request through our privacy centre at canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit canadalife.com/privacy.

Privacy consent, authorizations and declarations

- I hereby apply for the benefits and coverage indicated on this form.
- I have read, understand and agree with the contents of the section on this form entitled "Privacy"

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, MIB, LLC., 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 tests and/or examinations, including (but not limited to) blood profiles and urinalysis, performed 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 and any other products, services or coverage I may be eligible to apply for, 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 MIB, LLC.;
- 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, to advise you of products, services or coverage you may be eligible to apply for, 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 and any other statements and answers I give in connection with this application are complete and true. I understand that if any statement or 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 it, 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.

☐ I authorize Canada Life to use the information collected during this application process to determine my eligibility for other Canada Life products or services, and to contact me if I am eligible. This may reduce or eliminate the need for any further medical questions, or tests, to qualify for additional products or services.

Employee signature _____ Date signed _____

Spouse signature _____ Date signed _____

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)

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Additional information

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