

Payment Calculation and Method of Payment

Please use the Rates booklet to calculate your total monthly premium and the initial payment that must be submitted with your application.

1. What is the basic monthly premium rate for the plan type and coverage category you've selected on the previous page?

<input type="checkbox"/> Single		\$	
<input type="checkbox"/> Couple		\$	
Number of children under age 5	_____ x Rate _____ =	\$	
Number of children age 5 and over	_____ x Rate _____ =	\$	
TOTAL		\$	

NOTE: The coverage category for all benefits must be the same (i.e. Single, Couple, etc.).

2. What is the monthly premium rate for any optional benefits you've selected on the previous page?
(Optional benefits are only available for Scales 1-4)

<input type="checkbox"/> Hospital Accommodation		\$	
<input type="checkbox"/> Emergency Travel Medical		\$	
<input type="checkbox"/> AD&D: _____ units (maximum 10) x monthly rate/unit _____ =		\$	
<input type="checkbox"/> Hospital Cash		\$	
TOTAL		\$	

3. **Total Monthly Premium** (add the totals from 1 and 2 above)

\$ _____

4. **Initial Payment** (Total Monthly Premium multiplied by 2)

\$ _____

Applications that are not accompanied by an initial payment will not be accepted.

Company - or Employer-Paid Policies

If your Sonata Health policy is being paid for by your company or employer, this section must be completed.
 (If you are paying for your policy personally, leave this section blank and continue to next section.)

Company Name	Company Address	
Contact Name	Phone Number	Signature

The payment information on the next page must also be completed by the employer.

Please provide the following information if you are losing coverage under group benefits plan.

Name of Employer	Date Benefits Ended (DD/MM/YYYY)
Insurance Company	Policy Number
	Cert or ID Number

Initial payment:

The initial payment is for 2 months premium. The initial payment will be held until the application is approved. If the application is not approved, the cheque will be returned, or the credit card payment will not be processed. **Please make cheques payable to Great-West Life.**

I would like to make the initial payment by:

Option 1: Cheque (please do not post-date cheques)

Option 2: **Visa** **MasterCard**

If your initial payment is by Visa or MasterCard: Card # _____ Expiry Date _____

Name of Credit Card holder

X _____
Signature of Cardholder

Subsequent premium payments:

I/We authorize my/our bank or financial institution to allow PAdmin Group*, on behalf of Great-West Life, to withdraw/charge the premium payment each month from the account/credit card shown below. This authorization may be cancelled at any time by providing notice to Great-West Life.

Signature of Account/Credit Card holder(s) **X** _____

I would like to make my monthly premium payments by:

Option 1: Pre-authorized withdrawal

Please include a cheque (marked "VOID") for the account from which you want the withdrawal to be made.

You will receive at least 10 days notice prior to the date of withdrawal if your premium payment amount changes.

OR

Option 2: **Visa** **MasterCard**

Name of Credit Card holder _____ Card # _____ Expiry Date _____

**Your monthly credit card or bank statement will show a payment to PAdmin Group for Sonata Health. PAdmin Group is an agent of Great-West Life. Premiums are due in advance on the 15th of each month. If the 15th of the month falls on a weekend or holiday, your account will be debited on the next business day.*

Agent's Use Only

Agent's Name HealthQuotes.ca Inc.		Agent's Great-West Life Number <u>Commission #091490</u> If not Great-West Life affiliated, indicate company affiliation: <input type="checkbox"/> London Life <input type="checkbox"/> Investors Group <input type="checkbox"/> Other	
Great-West Resource Centre	Branch Office	Company Name (if other)	
Agent's Business Address 5145 Steeles Ave. West, Entrance A, Suite 202	City Toronto	Province ON	Postal Code M9L 1R5
Agent's Telephone Number 1-800-474-4474	Agent's E-mail Address		

Agent's Signature

Policy documentation will be sent to the policyholder. If you wish to have it sent to you, check here:

If you checked the box above, how would you like to receive the documents? Paper copies or PDF Files (by e-mail)

Medical and Lifestyle Questionnaire

Eligibility for coverage for you, your spouse and any dependent children will be based on the medical history provided. ***It is important that you answer all of the questions completely and accurately.***

Applicant _____ Spouse _____
First Name Last Name First Name Last Name

1. Have you, your spouse or a dependent child gained or lost 20 lbs (9 kgs) or more in the past year? Yes No If yes, indicate who: _____
 Amount gained: _____ Amount lost: _____ Reason: _____
2. In the past 24 months have you, your spouse or a dependent child consulted a physician or received (or are you expecting to receive) medical treatment including prescription medications or scheduled tests, procedures or surgery for any of the following:

Note: If you answer Yes to any of the following questions, please provide more information in Question 3.

	Applicant		Spouse		Dependant		If Yes is indicated for a dependant, provide name.
	Yes	No	Yes	No	Yes	No	
a) High blood pressure, stroke, TIA (transient ischemic attack) or chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) High cholesterol or any other blood disorder, heart or circulatory disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Nervous, mental, emotional or neurological disorder (including depression, anxiety, chronic fatigue or fibromyalgia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Liver disease or disorder including hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) Stomach, intestinal, bladder, bowel or kidney disorder (including ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
f) Asthma, allergies, or respiratory disorder, including shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
g) Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
h) Bone, joint or other musculoskeletal disorders, including arthritis and rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
i) Cancer, tumor or any growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
j) Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
k) Chronic headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
l) Diabetes, except gestational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
m) Any other condition, disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. Please provide details to any questions to which you've answered Yes in Question 2. Use a separate page if more space is required.

Name	Test, injury, illness, operation, complication	Medication (strength, e.g.50 mg.)	Daily dosage	Monthly cost	Date of onset	Date of recovery	Results of treatment and extent of recovery	Name and address of treating physicians

Medical Underwriting

If coverage is offered at a higher premium or is modified due to you or your family member's medical history, you will be provided with a conditional offer of acceptance. The conditional offer of acceptance allows you to review the revised terms or decline the coverage. If you choose not to proceed with coverage, your initial premium will be returned to you and your application cancelled.

Great-West Life reserves the right to decline coverage for an applicant, spouse or dependant based on the medical assessment.

Failure to complete this application in its entirety will result in delays.

Beneficiary Designation for Accidental Death

Please complete this section ONLY if you selected optional AD&D coverage. You (the applicant) are automatically the beneficiary for accidental death benefits payable for your spouse and children. However, you may designate a beneficiary for yourself. If you do not make a beneficiary designation, benefits will be paid to your estate. If you designate a beneficiary under the age of 18, or one who is not able to give a valid discharge, benefits will be paid into court, unless a trustee is appointed. If appointing a trustee, you must complete the "Appointment of Trustee" form [M6063(IBP) BIL] available from your financial security advisor or consultant, PDAdmin Group (1-800-268-3489) or email sonatahealth@pdadmin.com or visit Client Services on www.greatwestlife.com.

Beneficiary's Full Legal Name	% of Proceeds	Relationship to the Applicant
1.		
2.		
3.		

- You must make your beneficiary designation revocable or irrevocable by checking one of the boxes below.
- You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your coverage under the policy without the written consent of the irrevocable beneficiary.
- Where Quebec law applies and you have designated your spouse (whether married or civil union spouse) as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable" below.

I hereby make the designation (check one): Revocable Irrevocable

Date _____ Signature of Applicant **X** _____

Declaration and Authorization

I/We have read all the statements, questions, and answers made in this application, and understand that they will form the basis of any policy issued.

I/We declare that the statements provided in this application and in the Medical and Lifestyle Questionnaire are true and complete and I/We agree that all such statements form the basis for any coverage approved or policy issued as a result of this application.

I/We understand that any injury or sickness, the signs of which first appeared on or before the date of this application, must be fully disclosed in this application. Facts known by me/us, but not stated in this application could result in the denial of a claim, or cancellation of any policy issued as a result of this application.

To the best of my/our knowledge and belief the answers and statements given in this application are complete and true. It is understood that if any statement or answer in this application misrepresents or fails to disclose any fact material to the insurance, any contract issued as a result of the application may be voided.

I/We consent to any personal or telephone interviews that may be required in connection with this application or policy issued as a result of this application.

I/We authorize any licensed physician, medical practitioner, hospital or clinic or other medical or medically related facility, insurance company, or any other organization, institution or person that has any records or knowledge of me or my health, or my spouse or children or their health, to release any such information to The Great-West Life Assurance Company (Great-West Life) (or any organization acting on its behalf) or its reinsurer(s).

I/We authorize Great-West Life to release personal information for underwriting, claims processing or other policy administration purposes to any party noted above, and to third party administrators, benefit service providers, and other insurance companies and reinsurers.

If any benefits under the policy applied for are reimbursed for expenses incurred as a result of the actions of a third party, I/we agree to transfer any legal rights arising from such actions to Great-West Life. Further, I/we agree to cooperate fully with any legal action taken by Great-West Life and to reimburse Great-West Life for any amounts recovered.

I/We certify that if applying for coverage for dependants, I/we are authorized to act on their behalf.

This authorization is valid until revoked in writing by me, subject to legal and contractual restrictions which may apply. I acknowledge that I am aware of the reasons the information covered by my consent is needed, as well as of the benefits and risks of (not) consenting.

I/We have read, and I understand and agree with the contents of the section above entitled "Protecting Your Personal Information".

I/We hereby apply for coverage under the policy issued by Great-West Life.

I/We understand that coverage shall become effective on the first day of the month following approval of this application by Great-West Life and PDAdmin Group, provided there has been no change in insurability of the persons for whom application is made. I/We understand that any change in insurability must be reported to Great-West Life or any coverage granted may be void.

No agent is authorized to amend, alter, modify or waive any terms of this application, or any contract of insurance issued.

I/We request that all communication and documents be in English. (Par les présentes, je demande expressément que toutes les communications et tous les documents soient en anglais.)

I/We confirm that a photocopy or an electronic copy of this application is as valid as the original.

Date signed: _____
DD / MM / YYYY

X

Signature of Applicant

Date signed: _____
DD / MM / YYYY

X

Signature of Spouse (if coverage applied for)

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We collect, use and disclose the personal information to process this application and, if this application is approved, provide and service the financial product(s) applied for, investigate and process claims, and create and maintain records concerning our relationship.

You may review and correct the information in your file. A request to review or correct your file should be made in writing and may be sent to any of **Great-West Life's offices or to our head office at: The Great-West Life Assurance Company, Attn: Personal Information Officer, P.O. Box 6000, Winnipeg, Manitoba R3C 3A5.**

Once You Have Completed This Application Please Ensure That:

- You, and your spouse, if applicable, have signed the authorization for pre-authorized payment on page 3.
- You, and your spouse, if you are applying for couple coverage, have signed and dated the Declaration and Authorization section on page 6.
- All the sections of the Medical and Lifestyle Questionnaire have been completed.
- A signed cheque for the first two months' premium is attached, and that it is made payable to Great-West or you have signed authorizing the initial payment from your Visa or MasterCard. (Please see page 3.)
- A personalized, blank cheque marked "void" needed to establish pre-authorized payment of premium is attached, or you have signed authorizing that subsequent payment be credited to your Visa or MasterCard. (Please see page 3.)
- You have completed and signed the Direct Deposit Authorization Form, if you want your health and dental benefit payments directly deposited into your bank account. (Please see page 1.)

If you have any questions or need help completing this form please call toll free at 1-800-474-4474

For the fastest possible coverage please fax your application.

Mail to:
Individual Health Applications
5145 Steeles Ave. West
Entrance A, Suite 202
Toronto, ON
M9L 1R5

Fax to:
Individual Health Applications
1-866-676-4581
(If the faxed application is not clear, you may have to mail in the original. If using pre-authorized payment then you must also fax us a copy of a void cheque. For assistance please call us.)

THE INSURANCE FOR WHICH YOU ARE APPLYING IS SUBJECT TO LIMITATIONS AND EXCEPTIONS.

If The Great-West Life Assurance Company approves your application, you will be issued a policy setting out the definitions, limitations and exceptions. We recommend you read the policy carefully upon delivery.

