

To apply for PlanDirect you must be age 50 or older and covered by the government health plan in your province of residence. Please refer to the PlanDirect brochure and Rates booklet for information on coverage available, who is eligible to join, and the cost.

1 PERSONAL INFORMATION (please print clearly)				
Last Name	First Name	Initial	Date of Birth - DD/MM/YYYY	Sex <input type="radio"/> M <input type="radio"/> F
Address		Apt. #	City	Province
Telephone Number	Business Phone Number	Fax Number	Covered by Provincial Medicare? <input type="radio"/> Yes <input type="radio"/> No	Language Preference <input type="radio"/> English <input type="radio"/> French
E-mail address (if available)	Check here if you would prefer to receive your policy documents by e-mail instead of on paper <input type="radio"/>		(For internal use) Trace #	
For couple or family coverage, please complete the following information about your dependants: (Attach a separate page if more space is required.)				
Full Name	Sex	Date of Birth DD/MM/YYYY	Weight kg/lb	Height cm/in
Spouse	<input type="radio"/> M <input type="radio"/> F			
Child	<input type="radio"/> M <input type="radio"/> F			
Child	<input type="radio"/> M <input type="radio"/> F			

2 PLAN TYPE, COVERAGE CATEGORY AND OPTIONS		
Please select the desired plan type:	Please select the coverage category desired:	Please select the options desired. Select all that apply.
<input type="radio"/> Value <input type="radio"/> Basic <input type="radio"/> Basic with Drug Card <input type="radio"/> Advantage <input type="radio"/> Comprehensive <input type="radio"/> Comprehensive with Drug Card <input type="radio"/> Premier	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	<input type="radio"/> Emergency Travel Medical <i>(Available only prior to age 70)</i> <input type="radio"/> AD&D - Number of Units (10 max) _____ <i>(Available only prior to age 71)</i> <input type="radio"/> Major Dental <i>(Available on Advantage or Comprehensive Plan)</i> <input type="radio"/> Hospital Cash <input type="radio"/> Enhanced Prescription Drug <input type="radio"/> \$2,500 deductible <input type="radio"/> \$5,000 deductible <i>(Available to applicants age 65 and under)</i>

3 BENEFICIARY DESIGNATION FOR ACCIDENTAL DEATH		
<p>Please complete this section ONLY if you have selected AD&D coverage.</p> <p>You (the applicant) are automatically the beneficiary for loss of life benefits payable for your spouse and dependants. 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, consultant, PDAdmin Group or on the Internet at www.greatwestlife.com/plandirect.</p> <p>I hereby designate the following beneficiary(ies) for my loss of life benefit:</p>		
Beneficiary's Full Legal Name	% of Proceeds	Relationship to Applicant
<p>NOTE: An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable. I hereby make the designation:</p> <p><input type="radio"/> Revocable <input type="radio"/> Irrevocable</p>		
_____	<p style="text-align: center;">X</p> <p>Signature of Applicant</p>	
Date		

4 MEDICAL AND LIFESTYLE QUESTIONNAIRE

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

Applicant

First Name _____ Last Name _____

Spouse

First Name _____ Last Name _____

1. In the last 24 months, have you or your spouse and/or children (if couple or family coverage is being applied for) been ill or disabled for two or more weeks, been confined to a hospital for three days or more, or had an injury requiring hospitalization? Yes No

If yes, please provide the following information.

Name of Person	Date of Illness, Injury, Disability, or Confinement	Date of Recovery from the Illness or Injury, or Date of Release from Hospital	Diagnosis of Illness or Injury

2. Are you, your spouse and/or your children (if couple or family coverage is being applied for) currently receiving or expecting to receive medical treatment including prescription medications or scheduled tests? Yes No

If yes, state the medical condition and how long you, your spouse and/or children have had the medical condition and the type of treatment. Also state the types and dosage of any medication.

Name of Person	Medical Condition	Start Date	Type of Treatment	Medication (include strength, e.g. 50 mg)	Daily Dose

Important Notice: If your health or the health of your spouse and/or children (if applying for couple or family coverage) changes between the date of your application and the date Great-West makes a decision on your application, you must inform PAdmin Group immediately. Failure to do so may jeopardize your health coverage.

4b Please complete this section only if you have selected the Enhanced Prescription Drug Option

1. Have you, your spouse or dependent child seen a physician in the last five years? Yes No

If yes, please advise date of last physicians visit and reason for visit.

Patient Name	Date of Visit	Reason for visit/tests	Result of visit/tests	Date of recovery

4b (continued) Please complete this section only if you have selected the Enhanced Prescription Drug Option

2. In the past five years 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:

	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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
b) High cholesterol or any other blood disorder, heart or circulatory disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
c) Nervous, mental, emotional or neurological disorder (including depression, anxiety, chronic fatigue or fibromyalgia)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
d) Liver disease or disorder including hepatitis.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
e) Stomach, intestinal, bladder, bowel or kidney disorder (including ulcers)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
f) Asthma, allergies, or respiratory disorder, including shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
g) Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
h) Bone, joint or other muscoskeletal disorders, including arthritis and rheumatism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
i) Cancer, tumor or any growth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
j) Skin disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
k) Chronic headaches or migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
l) Diabetes, except gestational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
m) Any other condition, disease or disorder (please provide details in question 3 below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

3. Please provide details for any questions to which you've answered Yes to 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

4. Have you, your spouse or dependent child been advised to undergo medical tests, investigation, hospitalization or surgery for any medical concern or condition not listed above? Yes No
If yes, please provide the details below. Use a separate page if more space is required.

Patient Name	Date of Visit	Reason for visit/tests	Result of visit/tests	Date of recovery

Medical Underwriting

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.

5 PREMIUM INFORMATION

Please see the Rates booklet to determine your rate category (Standard, Preferred, Preferred Plus or Guaranteed Acceptance*) and premium rate by province, plan type selected, and coverage category selected, i.e. family status (Single, Couple, Family).

My rate category is: Preferred Plus Preferred Standard Guaranteed Acceptance*

Please use Guaranteed Acceptance **only if not completing the medical questionnaire.*

If you are applying for Preferred or Preferred Plus Rates, please provide us with the following proof of prior insurance coverage:

- A letter from your employer stating the date your benefits terminated and type of benefits (i.e. Health or Health and Dental). **OR**
- A copy of a summary of benefits from the previous carrier.

Note: proof of major restorative dental coverage, such as crowns, is required when applying for the Premier Plan or for the Major Dental Services and Supplies Benefit option with Advantage or Comprehensive Plan coverage.

Also, please provide the following information if you are terminating a group plan:

Name of Employer		Date Benefits End - DD/MM/YYYY
Insurance Company	Policy #	Certificate or Identification #

6 PAYMENT CALCULATION AND METHOD OF PAYMENT

Please refer to the Rates booklet to calculate your total monthly premium. Note: the coverage category for all benefits must be the same (i.e. Single, Couple or Family). See Part 2 of the application for the plan type and coverage category you selected.

1. What is the base monthly premium rate for the plan type and coverage category you have selected?.....\$ _____
2. What is the monthly premium rate for any optional benefits you have selected?
 - a) Emergency Travel Medical Benefit\$ _____
 - b) AD&D Benefit _____ units (maximum 10) x monthly rate/unit _____ = \$ _____
 - c) Hospital Cash Benefit\$ _____
 - d) Major Dental Services and Supplies Benefit (Advantage or Comprehensive Plans only)\$ _____
 - e) Enhanced Prescription Drug Benefit - \$2,500 deductible \$ _____
 - \$5,000 deductible \$ _____
3. **Total Monthly Premium** (add 1, 2a, 2b, 2c, 2d and 2e)\$ _____
4. **Initial payment enclosed** (Total Monthly Premium multiplied by 2)\$ _____

Company-Paid or Employer-Paid Policies

If your PlanDirect 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 Initial Payment.)

Company Name and Address		
Company Phone Number	Contact Name	Signature

The payment information below must also be completed by the employer.

Initial Payment

With your application, please include a current dated cheque for the initial payment for 2 months, payable to PAdmin Group. Your initial payment will be held until your application is approved. If your application is not approved, your cheque will be returned.

Subsequent Premium Payments

Your monthly pre-authorized premium payments will be withdrawn from your chequing/savings account. 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.

Signature of account holder(s) **X** _____ **X** _____

Name of account holder(s) _____ (please print clearly) _____ (please print clearly)

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.**

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.

NO APPLICATION WILL BE ACCEPTED WITHOUT THE SIGNATURE OF ALL APPLICANTS.

No information, statements, representations or answers with respect to any questions in this application shall be deemed to have been communicated to or be binding on The Great-West Life Assurance Company unless set out in this application.

ONCE YOU HAVE COMPLETED THIS APPLICATION PLEASE ENSURE THAT:

- A signed cheque for the first two months' premium, made payable to PAdmin Group, is attached.
- You have included a personalized, blank cheque marked "VOID" (needed to establish pre-authorized payment).
- You, and your spouse if applicable, have signed the authorization for pre-authorized payment.
- All sections of the Medical and Lifestyle Questionnaire have been completed.
- You, and your spouse if you are applying for couple coverage, have signed and dated the Declaration and Authorization section.
- You have attached proof of prior insurance coverage if you are applying for Preferred or Preferred Plus rates.
- You have completed and signed the Direct Deposit Authorization section if you want your health and dental benefit cheques directly deposited into your bank account.

Return your completed application to your financial security advisor or consultant or mail it to:

PAdmin Group
211 Consumers Road, Suite 200
Willowdale ON M2J 4G8

If you have any questions or need help completing your form, please contact your financial security advisor, consultant or PAdmin Group:

Phone (Toronto Area): (416) 490-0072
Toll-free anywhere in Canada: 1-800-565-4066
Fax: (416) 490-6640
E-mail: questions@plandirect.com