

To apply for PlanDirect applicants must be covered by the government health plan in their 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.

(For internal use) Trace # _____

1 PERSONAL INFORMATION (please print clearly)					
Last Name	First Name	Initial	Date of Birth - DD/MM/YYYY	Ht ___ cm ___ in Wt ___ kg ___ lbs	Sex <input type="radio"/> M <input type="radio"/> F
Address		Apt. #	City	Province	Postal Code
Telephone Number	Business Phone Number	Fax Number	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 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 (Available only prior to age 70) <input type="radio"/> AD&D - Number of Units (10 max) _____ (Available only prior to age 71) <input type="radio"/> Major Dental (Available on Advantage or Comprehensive Plan) <input type="radio"/> Hospital Cash <input type="radio"/> Enhanced Prescription Drug <input type="radio"/> \$2,500 deductible <input type="radio"/> \$5,000 deductible (Available to applicants age 65 and under)

3 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: <input type="radio"/> Preferred <input type="radio"/> Preferred Plus <input type="radio"/> Standard <input type="radio"/> 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:		
<ul style="list-style-type: none"> 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 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 #

4 MEDICAL AND LIFESTYLE QUESTIONNAIRE

Eligibility for coverage for you, your spouse and any dependant 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 ENHANCED PRESCRIPTION DRUG OPTION

Are you selecting this option? If yes, please complete questions below. If no, please proceed to Section 5 on page 4.

1. Have you, your spouse or dependant child seen a physician in the last five years? Yes No
 If yes, please advise date of last physician's visit and reason for visit.
 If no, move to section 5.

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 dependant 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 musculoskeletal 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 dependant 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 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)\$ _____

Initial payment:

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

Subsequent premium payments:

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

Signature of Account holder(s) _____

Pre-authorized debit ("PAD"):

Subsequent premium payments will be made by pre-authorized monthly withdrawals from the account holder's financial institution. Please provide the following information. If the account is a chequing account include a cheque (marked *Void*) for the account from which you want the withdrawals to be made.

i. Name, branch, and address of Canadian Financial Institution:

Transit number:	Institution number:	Account number:

ii. Does the account require more than one account holder signature? Yes No

iii. Type of account (must have electronic funds transfer privileges):

- Personal chequing Current/business Savings

*Your monthly bank statement will show a payment to PAdmin Group for Plan Direct. 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.

Company-Paid or Employer-Paid Policies

If your PlanDirect policy is being paid by your company or employer, please have them complete the M6995(PD) Company or Employer paid form.

9 PRE-AUTHORIZED DEBIT AGREEMENT DECLARATION AND AUTHORIZATION

1. I/We acknowledge and agree that the statements and answers provided in this application will form the basis of any policy issued as a result of this application.
2. 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.
3. I/We declare that the statements and answers provided in this application are true and complete to the best of my/our knowledge and belief and I/we understand that if any statement or answer in this application misrepresents or fails to disclose any fact material to the insurance, any policy issued as a result of the application may be voided.
4. I/We acknowledge that I/we have had the opportunity to review information on rates, fees, limitations, features, benefits and other product information.
5. I/We authorize and consent to any physician, medical practitioner, hospital or medically related facility, insurance company or any other organization, institution or person that has any information concerning 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).
6. I/We authorize and consent to Great-West Life and reinsurer(s) collecting, using and disclosing personal information as may be required for underwriting, administrative and claim purposes, including the purposes set out in the section entitled "Protecting Your Personal Information" and such other purposes as otherwise identified to or known by me. I/we have read and I/we understand and agree with the contents of the section entitled "Protecting Your Personal Information".
7. These authorizations and consents will begin the date they are given and may be revoked at any time by written notification by me/us, subject to legal and contractual restrictions which may apply. I/We acknowledge that I am/we are aware of the reasons the information covered by my/our authorizations and consents is needed, as well as the benefits and risks of consenting or not consenting.
8. If I/we have chosen the Pre-Authorized Debit (PAD) method of payment, I/We declare that I/we have received, read, understood and agree with the applicable terms and conditions as set out in the Pre-Authorized Debit ("PAD") Agreement.
9. I/We hereby apply for coverage and I/we understand that coverage shall become effective on the first day of the month following approval of this application by Great-West Life or PDAAdmin Group acting on its behalf, provided there has been no change in insurability of the persons for whom the application is made.
10. 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.
11. No agent is authorized to amend, alter, modify or waive any terms of this application or any contract of insurance issued.
12. I/We certify that if applying for coverage for dependants, I am/we are authorized to act on their behalf.
13. I/We agree that the use of any card issued in connection with the policy constitutes my/our agreement with any terms and conditions of the card, and that the use of any such card authorizes the use and exchange of personal information by Great-West Life and its service provider with: each other, pharmacies, other healthcare providers, other insurers, reinsurers, administrators of government or other benefits programs, and other organizations and service providers when necessary to assess and manage claims and administer benefits.
14. I/We request that this application, the policy, and all related documents be in English. Je demande / Nous demandons que la présente proposition, la police et tous les documents s'y rapportant soient rédigés en anglais.
15. I/We confirm that a photocopy or an electronic copy of this declaration and authorization is as valid as the original.

Signed at _____ on _____
City Province MM DD YYYY

X _____ **X** _____
 Signature of **Applicant** Signature of **Spouse** (if spousal coverage applied for)

X _____ **X** _____
 Signature of **account holder** (if other than the Applicant and method of (PAD)) Signature of **joint account holder** (required for joint account)

**10 Remove and Retain
Pre-Authorized Debit Agreement
Terms and Conditions**

<ul style="list-style-type: none"> • Authorization 	<p>Note: References to “this PAD agreement” include later amendments to it.</p> <p>I, the account holder, authorize The Great-West Life Assurance Company (Great-West) and my financial institution named (or any other financial institution I may authorize at any time) to withdraw monthly from my account and payments that I have agreed to make under this agreement as though I had personally signed a cheque. I understand that changes to the policy, including as applicable to premium amounts or to the method or required amount of payment or termination and recommencement of automatic premium payments under this PAD agreement may increase or decrease the monthly amount withdrawn or to be withdrawn from my account. Accordingly, I authorize such increases or decreases, waiving any pre-notification requirement with respect to them.</p> <p>I consent to Great-West's collection, use, retention and exchange of personal information concerning me, in my capacity as account holder and only as required for purposes relating to this PAD agreement. If I am not also the owner of a policy covered by this PAD agreement, I authorize Great-West to share with the owner(s) of such policy any information relating to this PAD agreement, including the payments and their source.</p> <p>I agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.</p>
<ul style="list-style-type: none"> • Signatures 	<p>I certify that all persons whose signatures are required to authorize this PAD agreement have signed, including any required joint account holder.</p>
<ul style="list-style-type: none"> • Account changes 	<p>I will notify Great-West if my financial institution, branch or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the next withdrawal date. Great-West may, but is not obligated to, rely on verbal instructions from me to amend this authorization.</p>
<ul style="list-style-type: none"> • Confirming withdrawals 	<p>I agree to regularly review my account information and if I question or disagree with the amount withdrawn or any account changes, I will notify Great-West in writing within 90 days of the withdrawal or account changes; otherwise, I agree that the withdrawal or account changes will be considered to have been properly made.</p>
<ul style="list-style-type: none"> • Non-sufficient funds (NSF) information 	<p>If there is not enough money in my account to cover the total monthly amount due (“due” as an amount owing, or as an amount otherwise specified to be withdrawn under this PAD agreement), I authorize Great-West to immediately make a second attempt to withdraw the amount due. If the second attempt is also returned NSF (or if Great-West decides, in its sole discretion, not to make the second attempt), I understand that pre-authorized payments may be suspended, and possibly cancelled by Great-West. I understand that I am responsible for any NSF charge(s).</p>
<ul style="list-style-type: none"> • Assignment 	<p>I hereby waive any requirement of prior written notice to me by Great-West of the assignment by Great-West of this PAD agreement.</p>
<ul style="list-style-type: none"> • Cancellation 	<p>This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by me or the owner(s) to Great-West or by Great-West to me or the owner(s).</p> <p>To obtain a sample cancellation form, or for more information on your right to cancel this PAD agreement, contact your financial institution or visit www.cdnpay.ca. To obtain more information on your PAD agreement, contact PAdmin Group as indicated on page 8 of this form.</p> <p>I, the owner, agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Great-West, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Great-West, in its sole discretion, may require a new written PAD agreement if this PAD agreement is cancelled for any reason.</p>
<ul style="list-style-type: none"> • Recourse 	<p>You have certain recourse rights if any debit does not comply with this PAD agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.</p>

Important notes: To make this PAD agreement effective for the current month, the completed application must be received by PAdmin Group at least 14 days prior to the withdrawal day. If the account holder is other than the owner, a copy of the Terms and Conditions of the PAD agreement should be provided to the account holder.

11 PROTECTING YOUR PERSONAL INFORMATION

Further to an application for any product or service, Great-West Life establishes a confidential file that contains personal information concerning you. The file is kept in the office of Great-West Life or of third parties acting on our behalf. Rights of access to personal information in the file are limited to our staff or persons authorized by us (e.g. service providers), whether located in Canada or elsewhere who require it to perform their duties to you and persons authorized by you, and, as personal information may be collected, used, or disclosed in or from Canada or elsewhere, access may also be had by persons authorized by the laws of Canada or elsewhere, as applicable. Your rights of access and correction of any inaccuracies may be exercised by writing The Ombudsman, The Great-West Life Assurance Company, 255 Dufferin Avenue, London, Ontario, Canada N6A 4K1. We collect, use and disclose your personal information to: **(1)** process this application and, if this application is approved provide and service the financial product(s) and/or service(s) applied for, **(2)** advise you by telephone or otherwise of products and services to help you plan for financial security, **(3)** respond to, investigate and process claims, **(4)** create and maintain records concerning our relationship as appropriate, and **(5)** fulfill such other purposes as are directly related to the preceding. Note: In accordance with legal requirements, a copy of the entire application, including personal information, may be included with the policy or be provided separately to the owner. For a copy of our Privacy Guidelines or for questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

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.

12 ONCE YOU HAVE COMPLETED THIS APPLICATION PLEASE ENSURE THAT:

- A signed cheque for the first two months' premium, made payable to PDAdmin 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.
- You have reviewed the Pre-Authorized Debit agreement.

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

PDAdmin 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 PDAdmin Group:

Phone (Toronto Area): 416.490.0072
Toll-free anywhere in Canada: 1.800.565.4066
Fax: 416.490.6640
E-mail: plandirect@pdadmin.com

PlanDirect is administered by PDAdmin Group.
PlanDirect policyowners are insured by The Great-West Life Assurance Company.
Great-West Life and key design are trademarks of The Great-West Life Assurance Company.