OPTIONAL LIFE INSURANCE
DECLARATION OF GOOD HEALTH

Please read carefully before signing this form.

Group No.	Policyholder
168074	GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

TO BE COMPLETED BY EMPLOYEE

Last name	First name
Date of birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other
Date of employment (mm/dd/yyyy)	Identification number
Amount of insurance (up to $100,000 in units of $10,000): $	
Within the past 2 years, I have neither been hospitalized for, required medication or treatment for, or consulted a physician (to include a follow-up visit) due to, or as a result of any of the following: alcohol or drug abuse, heart or circulatory disorder, stroke, cancer or leukemia, diabetes, high blood pressure, chronic kidney or liver disease, mental, nervous or neurological disorders, lung disorders, aids (acquired immune deficiency syndrome), ARC (aids related complex), or had tests indicating exposure to the aids virus.	
Signature of employee	Date

TO BE COMPLETED BY SPOUSE

Last name	First name
Date of birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other
Date of employment (mm/dd/yyyy)	Identification number
Amount of insurance (up to $100,000 in units of $10,000): $	
Within the past 2 years, I have neither been hospitalized for, required medication or treatment for, or consulted a physician (to include a follow-up visit) due to, or as a result of any of the following: alcohol or drug abuse, heart or circulatory disorder, stroke, cancer or leukemia, diabetes, high blood pressure, chronic kidney or liver disease, mental, nervous or neurological disorders, lung disorders, aids (acquired immune deficiency syndrome), ARC (aids related complex), or had tests indicating exposure to the aids virus.	
Signature of spouse	Date

PRIVACY

Protecting Your Personal Information

At The Canada Life Assurance Company, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

CONTINUE ON REVERSE SIDE

M7307(168074)-7/20

AUTHORIZATIONS AND DECLARATIONS

I hereby apply for the changes in coverage under the group benefits plan issued by Canada Life.

I have read and understand and agree with the contents of the section on this form entitled “Protecting Your Personal Information”.

I authorize:

- my plan sponsor to deduct from my pay and remit to Canada Life the employee contributions required under the plan, if applicable;
- Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.
- Canada Life may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do no wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Canada Life.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Employee signature: _____ **Date:** _____

For amounts of insurance in excess of $100,000 please complete the regular medical questionnaire M5995(GNLHO).

Clear