APPLICATION

Underwritten by THE Great-West Life ASSURANCE COMPANY

To apply for Sonata Health, you must be covered by the government health plan in your province of residence. Please refer to the Sonata Health brochure and Rates booklet for information on coverage available, who is eligible to join, and the cost, or, visit *www.greatwestlife.com/sonata*.

Personal Information

For internal use: Trace # ____________________

Last name	First name	Initial	Sex ❑ M ❑ F
Address	City	Province	Postal Code

Telephone number: Home (   ) Business (   ) Cell (   ) Fax (   )

Email address | Language preference ❑ English ❑ French

Applicant's date of birth (DD/MM/YYYY) | Height ________ ❑ m/cm ❑ ft/in | Weight ________ ❑ kg ❑ lb | Occupation

Please complete this section if you are selecting couple or family coverage below. Use a separate page if more space is required.

First name	Initial	Last name	Sex	Date of birth (DD/MM/YYYY)	Weight ❑ kg ❑ lb	Height ❑ m/cm ❑ ft/in
Spouse			❑ M ❑ F	______/______/______		
Child 1			❑ M ❑ F	______/______/______		
Child 2			❑ M ❑ F	______/______/______		

Plan Type, Coverage Category and Optional Coverage

Please select the plan type:	Please select the coverage type:	Please select the optional coverage(s):
❑ Core (Medical Questionnaire must be completed) ❑ Core - Guaranteed Acceptance (I choose not to complete the Medical Questionnaire) ❑ Core Plus (Medical Questionnaire must be completed) ❑ Elite - With dental (Medical Questionnaire must be completed) ❑ Elite - Without dental (Medical Questionnaire must be completed)	❑ Single ❑ Couple ❑ Family	❑ Hospital Accommodation ❑ Major Dental (available only with our Core Plans) ❑ Hospital Cash ❑ Emergency Travel Medical ❑ Accidental Death, Dismemberment and Specific Loss (AD&D). Available in units $25,000 to a maximum benefit amount of $250,000. Number of units you want to purchase (maximum 10): ________ units

Prior Coverage

If you are losing coverage under a benefits plan, please provide the following information in a letter from your employer stating the date benefits ended and the type of benefits provided (i.e. health and/or dental) or a copy of a summary of benefits from the previous carrier. If your prior carrier was The Great-West Life Assurance Company, proof is not required.

Name of employer/plan		Date benefits end (DD/MM/YYYY)
Insurance company	Policy number	Certificate or identification number,

Medical Questionnaire

Primary applicant - last name, first name	Spouse - last name, first name
Dependant 1 - last name, first name	Dependant 2 - last name, first name

1. In the last 24 months, have you, your spouse and/or child:	Primary		Spouse		Dependant(s)	
	Yes	No	Yes	No	Yes	No
a) received medical treatment, prescribed medication or scheduled tests? b) been advised or become aware of a medical condition that may require medical treatment, prescribed medication or scheduled tests?	❑	❑	❑	❑	❑	❑

If yes, please provide the following information. Use a separate page if more space is required.

Name of applicant	Condition	Start date	Treatment/Medication (incl. dosage)/test
Name of applicant	Condition	Start date	Treatment/Medication (incl. dosage)/test
Name of applicant	Condition	Start date	Treatment/Medication (incl. dosage)/test

IMPORTANT NOTICE: If your, your spouse's and/or your dependants' health changes between the date of your application and the date Great-West Life makes a decision on your application, you must inform PDAssure immediately. Failure to do so may jeopardize your health coverage.

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? 1.

- ❑ Single $ ________
- ❑ 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 coverage you've selected on the previous page? 2.

- ❑ Hospital Accommodation $ ________
- ❑ Major Dental $ ________
- ❑ Hospital Cash $ ________
- ❑ Emergency Travel Medical $ ________
- ❑ AD&D: ______ units (maximum 10) x monthly rate/unit ________ = $ ________

TOTAL $ ________

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

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

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

Company-Paid or Employer-Paid Policies

If your Sonata Health policy is being paid for by your company or employer, please have them complete the M6995 Company or Employer paid form. Please contact PDAssure at the phone number listed on page 4 to obtain this form.

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, 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 ________

X ________________________
Name of Credit Card Holder

X ________________________
Signature of Cardholder

Subsequent premium payments:

I/We authorize my/our bank or financial institution to allow PDAssure*, 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 written notice to Great-West Life.

❑ **Option 1:** **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 and branch of address of Canadian financial institution:

Transit number:	Institution number:	Account number:

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

*(If **yes**, the account holders are required to authorize the* PAD *agreement and **must** sign* Declarations and Authorizations *on page 6.)*

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

❑ Personal chequing ❑ Current/business ❑ Savings

Please refer to form M7215 for terms of agreement.

OR

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

Name of Credit Card holder X ________________ Card # ________________ Expiry Date ________

Pre-Authorized Debit (PAD) Declaration. If this account requires more than one authorized signature, all authorized signatures must sign below.

By signing below you agree to the Pre-Authorized Debit ("PAD") Agreement (M7215), provided together with the application. Your monthly bank statement will show a payment to PDAssure for Sonata Health. PDAssure is a wholly owned subsidiary of The Great-West Life Assurance Company. Premiums are due in advance on the 15th of each month. If the 15th of the month fails on a weekend or holiday, your account will be debited on the next business day. If for any reason your payment is returned by the bank, a second attempt will occur on the 22nd of the month (unless this day falls on a weekend or holiday).

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 (M7215). I/We authorize my/our financial institution to allow PDAssure, on behalf of Great-West Life, to withdraw/debit the premium payment each month from the account shown above. You have certain recourse rights if any debit does not comply with this agreement. Form more information regarding your recourse rights, contact your Financial institution or visit *www.cdnpay.ca*.

X ________________________
Signature of account holder(s)

X ________________________
Signature of account holder(s)

Direct Deposit Authorization - Please complete if you wish to have direct deposit of claim payments.

Please deposit my claims in the following account. Note: for financial institutions within Canada only.

Name, branch and address of Canadian financial institution

Transit number	Institution number	Account number

Type of account (account must have electronic fund privileges):

❑ Personal chequing ❑ Chequing current/business ❑ Savings

I/We authorize:
- Great-West Life to deposit reimbursement for claims directly to the above account;
- Great-West Life and my financial institution to exchange personal information, when necessary to administer the plan.

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

X ______________________ Signature of account holder(s)

X ______________________ Signature of account holder(s)

Beneficiary Designation for Optional Accidental Death, Dismemberment and Specific Loss Benefit

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, PDAssure or *www.greatwestlife.com/sonata*.

I hereby designate the following beneficiary(ies) for my loss of life benefit:

Beneficiary's full legal name	% of proceeds	Relationship to applicant

For Québec Residents Only

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: ❑ Revocable ❑ Irrevocable

Date	Signature of applicant

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 ON 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 Great-West Life 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.

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 notificaton 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 PDAssure 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 ______________________
Signature of **Applicant**

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

X ______________________
Signature of **account holder** (if other than the Applicant and method of payment is PAD)

X ______________________
Signature of **joint account holder** (required for joint account)

Advisor / Consultant Information

Advisor/Consultant name (please print) Suzanne Oepkes			Commission account number 10004917
Company name Investors Group			Branch/Sales & Marketing Centre
Address 10 Island Shore Blvd, Winnipeg, Manitoba, R3X 0E7			ICS ❑ Yes ❑ No
Phone Office 204-257-0999	Cell	Fax	Email suzanne.oepkes@investorsgroup.com
Advisor/Consultant signature			Policy documentation will be sent directly to your client. You will receive a copy of the correspondence or, ❑ Please check here if you wish the policy documentation be sent to you for delivery to your client.

If you have any questions or need help filling out your form, please contact your financial security advisor, consultant or PDAssure:

Phone (Toronto Area) 416-499-4125
Toll free anywhere in Canada 1-800-565-4066
Fax 416-490-6640
Email sonatahealth@pdassure.com

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

PDAssure
200-211 Consumers Road
Willowdale ON M2J 4G8

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