

GWL Certificate Number

APPLICATION FOR NON-SMOKER RATE FOR OPTIONAL INSURANCE

Please print clearly and complete this form, in BLUE INK. The plan administrator should keep a copy of the completed form for their records and send the **original** to The Great-West Life Assurance Company.

1. General Enrollment Information	Plan number: <u> 31394 </u> Member ID: _____ Name of insured: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> last name first name middle initial </div> Date of birth: Month _____ Day _____ Year _____
2. Smoking Declaration	i) Do you now, or have you smoked any cigarettes within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No ii) In the past 2 years have you been treated for or had any indication of heart disease, stroke, cancer, or any respiratory disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details _____ _____ _____
3. Privacy This section explains Great-West Life's commitment to privacy.	<p>Protecting Your Personal Information</p> <p>At The Great-West 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 Great-West Life or the offices of an organization authorized by Great-West 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 Great-West Life. Great-West Life may use service providers located within or outside Canada. 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. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.</p>
4. Authorizations and Declarations This section must be signed and dated in BLUE INK by the insured.	I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form. I authorize: <ul style="list-style-type: none"> • Great-West 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 Great-West Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan. I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original. I understand that I must submit an original signed copy of this form. I certify that the information given is true, correct and complete to the best of my knowledge. Signature of insured: _____ Date: _____