

Return to:  
PDAdmin Group  
200 - 211 Consumers Road  
Willowdale, ON M2J 4G8

**Application Form**  
**Questions? Call 1-800-565-4066 for Assistance**

**Part 1 - Personal Information**

Last Name		First Name	Initial	Gender M F	
Address			Apt. #	Date of Birth (DD/MM/YYYY)	
City	Province	Postal Code		Language <input type="checkbox"/> English <input type="checkbox"/> French	
Phone	Business Phone	Ext.	Fax	Covered by Provincial Health Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email			<input type="checkbox"/> Check here if you would like to receive your policy documents by e-mail instead of paper.		
For couple or family coverage, please complete the following information about your dependants:					
Full Name		Gender	Date of Birth (DD/MM/YYYY)	Covered by Provincial Health Care	
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dependant		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dependant		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dependant		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Part 2 - Plan Type, Coverage Category**

Please select the desired plan type:		Please select the optional benefits desired:			
<input type="checkbox"/> Advantage Plan		<input type="checkbox"/> Hospital Cash		<input type="checkbox"/> Major Dental	
<input type="checkbox"/> Comprehensive Plan with Drug Card		<input type="checkbox"/> Emergency Travel Medical (Available only prior to age 70)		<input type="checkbox"/> AD&D - Number of Units (10 Max) _____ (Available only prior to age 71)	
Please select the coverage category desired:					
<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family					

**Part 3 - Prior Coverage**

Please provide us with the following information regarding your previous coverage

Company Name		Dates Benefits End (DD/MM/YYYY)
Insurance Company	Policy Number	Certificate/ID Number

**Part 4 - Premium Calculation**

Those with previous coverage within the last 60 days who can answer NO to the two medical questions in Part 5 please use the Preferred Plus rate.  
 Those with previous coverage within the last 60 days who cannot answer NO to the two medical questions in Part 5 please use the Preferred rate.  
 Those who are not approved for the Preferred rates will be eligible for Guaranteed Acceptance rates.

<b>Health Plan Premium</b>	<input type="checkbox"/> Preferred Plus	<input type="checkbox"/> Preferred	Monthly Premium _____
<b>Optional Benefit Premium</b>	<input type="checkbox"/> Hospital Cash		Monthly Premium _____
	<input type="checkbox"/> Major Dental Option		Monthly Premium _____
	<input type="checkbox"/> Emergency Travel Medical		Monthly Premium _____
	<input type="checkbox"/> AD&D		Monthly Premium _____
			<b>Total Monthly Premium</b> _____
<b>Initial Payment</b> ➤			<b>Total Monthly Premium X 2</b> _____

**Initial Payment**

The initial payment is for 2 months premium. The initial payment will be held until the application is approved. If the application is not approved your cheque will not be cashed or your credit card payment will not be processed.

I/We authorize my/our bank or financial institution to allow PDAdmin Group to withdraw/charge the premium payment each month from the account/credit card shown below.

I would like to make the initial payment by:  Visa  MasterCard  Cheque

If your initial payment is by cheque, please include a current dated cheque for the initial payment of 2 months premium, payable to PDAdmin Group. If your initial payment is made by Visa or MasterCard, please complete the following section:

Credit Card Number _____	Expiry Date _____
X _____	X _____
Name of Credit Card Holder	Signature of Card Holders

**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. I/we authorize PDAdmin Group to withdraw the monthly premiums from my/our account.

Name of Account Holder(s) _____	
X _____	X _____
Signature of Account Holders(s)	Signature of Account Holders(s)

Your monthly credit card or bank statement will show a payment to PDAdmin group for PlanDirect. Premiums are due in advance on the 15<sup>th</sup> of each month. If the 15<sup>th</sup> of the month falls on a weekend or holiday, your account will be debited on the next business day.

Return to:

PDAdmin Group  
200 - 211 Consumers Road  
Willowdale, ON M2J 4G8

**Application Form**  
**Questions? Call 1-800-565-4066 for Assistance**

**Part 5 - Medical & Lifestyle Questionnaire**

Eligibility for rate category will be based on the medical information provided. It is important that you, your spouse and any dependant children answer all the questions completely and accurately.

Applicant First Name (Please print clearly)

Applicant Last Name

Spouse First Name (Please print clearly)

Spouse Last Name

<b>1</b>	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
----------	---	------------------------------	-----------------------------

If yes please provide the following information.

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

If additional space is required please attach a separate sheet.

<b>2</b>	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 DD/MM/YYYY	Type of Treatment	Medication (include strength, e.g. 50 mg)	Daily Dose

If additional space is required please attach a separate sheet.

**Part 6 - Declaration, Authorization and Signatures**

- ◆ I/We have read all the statements, questions, and answers made in this application, and understand that they will form the basis of any policy issued.
- ◆ I/We declare that the statements provided in Parts 1 to 4 of this application and in the Medical and Lifestyle Questionnaire are true and complete and I/we agree that all such statements form the basis for any coverage approved or policy issued as a result of this application.
- ◆ 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. Facts known by me/us, but not stated in this application could result in the denial of a claim, or cancellation of any policy issued as a result of this application.
- ◆ To the best of my/our knowledge and belief, the answers and statements given in this application are complete and true. It is understood that if any statement or answer in this application misrepresents or fails to disclose any fact material to the insurance, any contract issued as a result of the application may be voided.
- ◆ I/We authorize any licensed physician, medical practitioner, hospital or clinic or other medical or medically related facility, insurance company, or any other organization, institution or person that has any records or knowledge of 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).
- ◆ I/We authorize Great-West Life to release personal information for underwriting, claims processing or other policy administration purposes to any party noted above, and to third party administrators, benefit service providers, and other insurance companies and reinsurers.
- ◆ 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.
- ◆ I/We certify that if applying for coverage for dependants, I/we are authorized to act on their behalf.
- ◆ This authorization is valid until revoked in writing by me/us, subject to legal and contractual restrictions which may apply. I/We acknowledge that I/we am/are aware of the reasons the information covered by my/our consent is needed, as well as of the benefits and risks of (not) consenting.
- ◆ I/We have read and I/we understand and agree with the contents of the section below entitled "Protecting your Personal Information".
- ◆ I/We hereby apply for coverage under the policy issued by Great-West Life.
- ◆ I/We understand that coverage shall become effective on the first day of the month following approval of this application by Great-West Life and PDAdmin Group, provided there has been no change in insurability of the persons for whom application is made. I/We understand that any change in insurability must be reported to Great-West Life or any coverage granted may be void.
- ◆ No agent is authorized to amend, alter, modify or waive any terms of this application, or any contract of insurance issued.
- ◆ I/We request that all communication and documents be in English. (Par les présentes, je demande expressément que toutes les communications et tous les documents soient en anglais.)
- ◆ I/We confirm that a photocopy or an electronic copy of this form is as valid as the original.

  X    
Signature of Applicant

  X    
Signature of Spouse (if applicable)

\_\_\_\_\_  
Date: (DD/MM/YYYY)

**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.