

**Instructions** – Please print all answers clearly.

1. Plan Member completes sections 1, 2, and 3. Physician completes section 4.
2. This form must be completed in full to avoid a delay in assessing the application. Once we have all the required information and have completed our assessment, we will notify the plan member in writing.
3. Please retain a copy of this form for your records.
4. Fees for providing medical information are the plan member's responsibility and are not covered under the plan.

**Please send completed form to:** Medical and Dental Services  
The Great-West Life Assurance Company  
PO Box 6000  
Winnipeg, MB R3C 3A5  
Fax: 204-938-2820

**Questions?** Call Toll Free: 1-800-957-9777 Or  
Refer to your Great-West Life Employee Benefits Booklet  
For the deaf or hard of hearing:  
Toll Free: 1-800-990-6654

<b>Section 1 – Plan Member Information</b>				
Plan Number	Plan Member I.D. Number			
Last Name	First Name			
Address	City and Province	Postal Code		
<b>Section 2 – Dependent Information</b>				
Last Name		First Name		
Relationship to Plan Member	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-Law <input type="checkbox"/> Other: _____		
<b>Residence of Dependent</b>				
Plan Member's Home <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Group Home <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Hospital <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Other: _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time	
<b>Dependent's Education</b>				
Highest level of education attained: _____		Is the dependent currently attending an educational facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes":	Is the dependent attending full time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Anticipated program completion date: (mm/dd/yy): _____		
Name of program and facility _____				
If "No":	When was the last day attended _____			
<b>Note: Please attach the most recent educational assessment and/or other assessments completed in the educational setting.</b>				
<b>Dependent's Employment</b>				
Has the dependent ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes" please provide the most recent date(s) and type(s) of employment.				
Period of employment (mm/dd/yy) to (mm/dd/yy)	Employer	Job Title	Average monthly income	Hours worked per week

**Section 3 – Authorizations and Declaration**

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of determining eligibility for coverage and administering the group benefits plan. 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](http://www.greatwestlife.com).

I authorize 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, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

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

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

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

Plan Member Signature \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_

**Section 4 – Attending Physician's Statement**

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Date(s) condition(s) diagnosed: \_\_\_\_\_

**Functional Abilities**

Does the patient have impairments in PHYSICAL functioning?  Yes  No Are the impairments permanent?  Yes  No  N/A

If the impairments are not permanent, when are they expected to resolve or improve? \_\_\_\_\_

Does the patient have impairments in COGNITIVE functioning?  Yes  No Are the impairments permanent?  Yes  No  N/A

If the impairments are not permanent, when are they expected to resolve or improve? \_\_\_\_\_

Please describe the nature and severity of any cognitive impairments. **(Attach any recent cognitive assessment and/or neuropsychological report.)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Does the patient have impairments in any of the following areas?**

Sitting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Ambulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Lifting/Carrying	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Manual dexterity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____

**Please indicate whether your patient requires assistance managing any of the following, and if so, describe supports needed:**

Personal care/hygiene <i>(bathing, dressing, toileting, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation <i>(driving, taking bus, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment <i>(taking medications, attending appts, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Routine/Schedule <i>(creating and adhering to a schedule)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal finances <i>(banking, paying bills, budgeting, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decision making <i>(using judgement to make good decisions)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home care <i>(cooking, cleaning, grocery shopping, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Planning <i>(ability to plan for the future)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Type(s) of supports required (*include physical supports, care supports, adaptive devices, etc*):

\_\_\_\_\_

Support is provided by (*include any agencies or people providing support*):

\_\_\_\_\_

**Treatment (*include medications, therapies, and other treatments; attach copies of recent investigations, assessments and consultations*)**

Date of last appointment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Describe the current treatment plan (use a separate page if necessary)

\_\_\_\_\_

\_\_\_\_\_

List any other physicians / care providers involved in the patient's treatment (use a separate page if necessary)

Name	Specialty	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Prognosis:** \_\_\_\_\_

Please provide any other comments you feel would assist us in understanding the patient's situation.

\_\_\_\_\_

\_\_\_\_\_

**I declare that the information in this section is true to the best of my knowledge.**

Physician's name (please print): \_\_\_\_\_ Specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_