Great-West Life ASSURANCE COMPANY

APPLICATION FOR NON-SMOKER RATE FOR OPTIONAL INSURANCE

For GWL Head Office Use Only

GWL Certificate Number

Please print clearly and complete this form, in 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: ______________________

Plan sponsor: ______________________

Plan member name: ______________________
last name first name middle initial

Division number: ______________ Plan member ID: ______________

2. Smoking Declaration

This section must be completed by the insured (plan member or spouse).

Name of insured: ______________________
last name first name middle initial

Date of birth: Month ______________ Day ______________ Year ______________

i) Do you now, or have you smoked any cigarettes within the past 12 months? ❍ Yes ❍ 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? ❍ Yes ❍ No

If yes, give details ______________________

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3. Privacy

This section explains Great-West Life's commitment to privacy.

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 use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

4. Authorizations and Declarations

This section must be signed and dated in INK by the insured (plan member or spouse).

Authorizations and Declarations

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 to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of this 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 Québec applicants: I request that this form be in English.

Je demande que ce formulaire me soit remis en anglais.

Signature of insured: ______________________ **Date:** ______________

M4672 BIL-10/04

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