THE Great-West Life ASSURANCE COMPANY

Application for Group Life Waiver of Premium Benefits
Employer's Statement

Important:
The completed Employer's and Employee's Statements are required before claim assessment can commence. **These forms should be completed in its entirety and submitted to Great-West Life at least 8 weeks prior to the end of the elimination period.** Great-West's Privacy Guidelines and applicable law allow employees to have access to personal information in their files. Please be aware that any information you provide us in connection with this claim may be subject to access by the employee.

Ensure all sections and both pages are completed as lack of information will cause delays in claim assessment.

A. EMPLOYER IDENTIFICATION

Name		Plan Number	Division Number (if applicable)	Class (if applicable)
Address: Street & Number	PO Box	City	Province	Postal code

B. EMPLOYEE IDENTIFICATION

Name: First	Initial	Last	Employee I.D. Number	Social Insurance Number	Date of Birth (MM/DD/YY)
Address: Street & Number		PO Box	City	Province	Postal Code
Telephone Number		Cell Number		Fax Number	

C. EMPLOYMENT INFORMATION

Effective date of hire (MM/DD/YY) _____ Date last worked (MM/DD/YY) _____ Number of hours _____

Reason for absence ☐ Medical ☐ Leave of Absence ☐ Strike ☐ Dismissed ☐ Work related accident or sickness
☐ Quit ☐ Retired ☐ Other ☐ Temporary Lay-off ☐ Paid Vacation

Is the employee: ☐ Full time: Number of hours worked per week _____ ☐ Part time: Number of hours worked per week _____

Is the employee: ☐ Permanent ☐ Temporary ☐ Seasonal ☐ Contract

Is the employee ☐ Hourly ☐ Salaried ☐ Commissioned

Please submit copies of all correspondence from Workers Compensation or similar coverage received to date regarding this condition.

Has employee returned to work?	If no, is a return to work date known?	Has employment terminated?
☐ Yes _____(MM/DD/YY) ☐ No	☐ Yes _____ (MM/DD/YY) ☐ No	☐ Yes _____ (MM/DD/YY) ☐ No

D. INSURANCE INFORMATION

Date employee became insured for basic life insurance with GWL.
(MM/DD/YY) _____

Was the employee a late applicant?
☐ Yes ☐ No

Effective date of excess insurance, if any:
(MM/DD/YY) _____

Date insurance or insurance premiums ended, if applicable:
(MM/DD/YY) _____

Is the employee covered for Guaranteed Standard Issue Program Insurance with Great-West Life? ☐ Yes _____ Plan Number ☐ No

E. EARNINGS AND BENEFIT INFORMATION

Employee's annual earnings on date last reported for work: $ _____ Amount of basic life insurance: $ _____

Please submit a copy of the LTD acceptance letter (if LTD benefits are provided by another carrier).

Is the employee covered for optional life insurance with Great-West Life? ☐ Yes ☐ No

If yes, provide the optional life plan number: _____ Amount of employee's optional life insurance $ _____

Please submit a copy of the employee's optional life approval letter.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Authorized Signature: _____ Date: _____

Name (please print): _____ Phone: _____

Title: _____ Fax: _____

Email Address: _____

F. JOB INFORMATION

Employee's job title as of last day worked	How long has the employee worked in this position? Years Months

COMPLETE THIS SECTION ONLY IF THE EMPLOYEE HAS NOT YET RETURNED TO WORK OR THE EMPLOYEE'S MEDICAL ABSENCE IS EXPECTED TO BE FOUR WEEKS OR LONGER. If you have a prepared job description, please include it with the submission.

What are the duties in this job, and what percentage of time does each take per week?

Duties	Percentage of time per week

To ensure proper management of this claim, more detailed job information may be requested at a later date.

When did the employee's disability first appear to affect his/her work? (MM/DD/YY)	In what ways did performance on the job change as a result of the disability?

Were any changes made in the employee's job duties as a result of the disability? ☐ Yes ☐ No
If yes, please explain what the changes were and when they were made:

If the employee could return to part-time or do less demanding work, would such work be available? ☐ Yes ☐ No
If no, please explain.

ADDITIONAL INFORMATION

Please provide any additional information that you believe should be considered in assessing this employee's claim.

DECLARATION

I HEREBY DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE AND COMPLETE.

Supervisor or Authorized Signature: _____ Date: _____

Name (please print): _____ Phone: _____

Title: _____ Fax: _____

Email Address: _____