THE Great-West Life ASSURANCE COMPANY

Application for Accidental Dismemberment or Specific Loss-Claimant's Statement Part 1

INSTRUCTIONS

1. **COMPLETE PART 1 AND AUTHORIZATION ON THE LAST PAGE OF PART 2. ASK YOUR PHYSICIAN TO COMPLETE PART 2.**
2. **FORWARD BOTH PART 1 AND PART 2 TOGETHER TO:**
   Public Employees Benefits Agency (PEBA)
   1000 - 1801 Hamilton Street
   Regina, SK S4P 4W3

Group Policy No.: 161938 Div No.: _____ Employee No.: _____

Name: _____

Address: _____
Street City Province Postal Code

Please check which Dismemberment or Specific Loss is being applied for:

- ☐ Both hands or both feet
- ☐ Entire sight of both eyes
- ☐ One hand and one foot
- ☐ One hand and entire sight of one eye
- ☐ One foot and entire sight of one eye
- ☐ Complete speech and complete hearing in both ears
- ☐ Use of both hands or both arms or both legs
- ☐ Use of one hand and one leg
- ☐ Use of one arm and one leg
- ☐ Paraplegia
- ☐ Hemiplegia
- ☐ Quadriplegia
- ☐ One arm or one leg or one hand or one foot
- ☐ Entire sight of one eye
- ☐ Use of one hand or one arm or one leg
- ☐ Complete loss of speech
- ☐ Complete loss of hearing in both ears
- ☐ Thumb and index finger of same hand

No more than $50,000 will be paid for all the losses incurred in any one accident.

Date of Accident: _____ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred: _____

Name of hospital if you were confined: _____

Dates of hospitalization: _____

Name of Attending Physician: _____

Physician's Address: _____
Street City Province Postal Code

Date of first treatment: _____

* If yes, please provide your accident report.

AUTHORIZATIONS AND DECLARATIONS

Protecting your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. Personal information about you is kept in confidential files in the office 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. We collect, use and disclose the personal information to administer the plan, investigate and assess claims, and create and maintain records concerning claims.

Authorizations and Declarations

I authorize:

Great-West Life, any physician, surgeon or any other person who has examined me, any hospital in which I have received treatment, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Great-West Life or working with my plan administrator, to exchange information, when relevant and necessary for the purpose of assessing my claim and to administering the plan;

I hereby declare that the answers given by me are, to the best of my knowledge and belief, true and full, and I have withheld no material facts from Great-West Life.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Signature _____ Date _____

Clear