THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR ACCIDENTAL DISMEMBERMENT OR SPECIFIC LOSS ATTENDING PHYSICIAN'S STATEMENT PART 2

Patient's Name: _____

Patient's Address: _____

Group Policy Number: **161938** Employee Number: _____

1. (a) When did the accident happen? Month _____ Day _____ Year _____

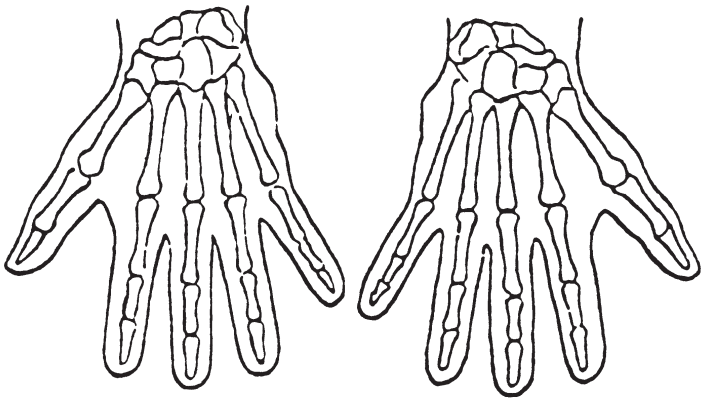
   (b) Briefly describe details of the accident. _____

2. (a) Date of first attendance for present injury. Month _____ Day _____ Year _____

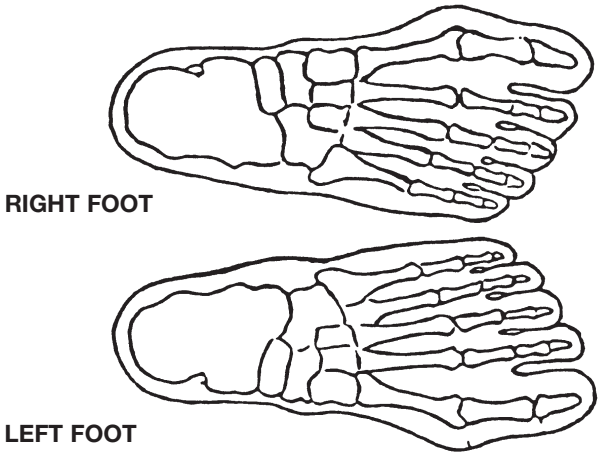
   (b) Date of most recent treatment. Month _____ Day _____ Year _____

3. (a) If the accident caused the loss of hand, foot fingers or toes, please indicate the point of amputation on the diagram below.

   (b) Date of amputation. Month _____ Day _____ Year _____

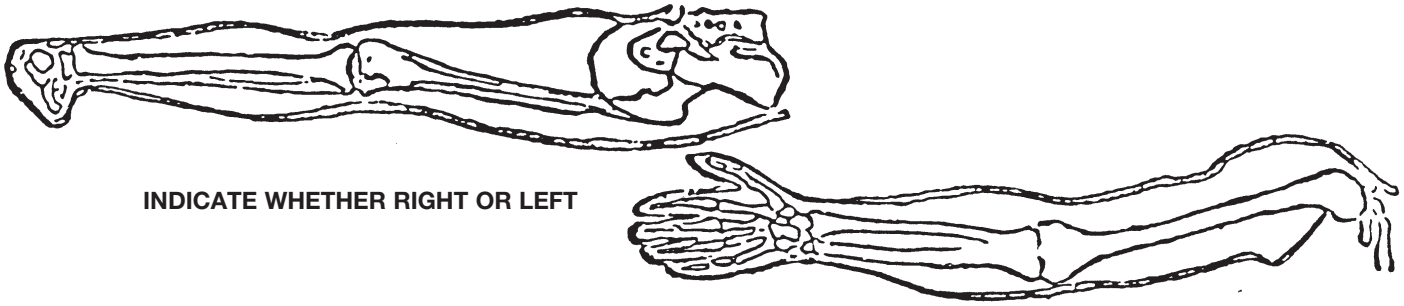


LEFT HAND RIGHT HAND



RIGHT FOOT

LEFT FOOT



INDICATE WHETHER RIGHT OR LEFT

4. (a) If the accident caused loss of use of leg, arm, hand(s), foot (feet) or thumb and index finger of same hand, please advise which.

(b) Is there any indication that the injured limb was unable to function normally prior to accident? ☐ Yes ☐ No

(c) Please indicate what functions, if any, the injured limb is able to perform.

5. (a) Was the injury described solely responsible for the loss? ☐ Yes ☐ No

(b) If not, give particulars of any contributing cause or causes.

LOSS OF SIGHT ONLY

6. If the accident caused total and irrecoverable loss of sight, please indicate:

(a) Date on which loss occurred. Month _____ Day _____ Year _____

(b) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

(c) If known to you, please advise the vision in each eye prior to the accident.

(d) What is the best corrected vision in the affected eye(s), If any?

Date _____ Signed _____ M.D.

Print Name _____

Address _____
Street City Province Postal Code

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