APPLICATION FOR NON-SMOKER RATE FOR OPTIONAL INSURANCE

Plannera PENSIONS & BENEFITS

For CL Head Office Use Only

CL Certificate Number

Please print clearly and complete this form, in INK.

1. General Enrollment Information

Plan number: 161938

Employer: _____

Plan member name: _____
last name first name middle initial

Division number: _____ Plan member ID: _____

2. Plan Member Information

This section must be completed by the plan member.

Please print clearly in INK.).

Plan member mailing address:

Street address: _____

City: _____ Province: _____ Postal Code: _____

3. 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) Have you used any Tobacco Products within the past 12 months? (tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish) ☐ 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 _____

4. Privacy

This section explains Canada Life's commitment to privacy.

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada 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 Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

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Please print clearly and complete this form, in INK.

5. Authorizations and Declarations

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

I hereby apply for coverage under the group benefits plan issued by Canada Life.

I have read and understand and agree with the contents of the section on this form entitled “Privacy”.

I authorize:

- my plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable;
- Canada Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Canada 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 Canada Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of the 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 Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: _____ **Date:** _____

Return to: Plannera
110 - 1801 Hamilton Street
Regina, SK S4P 4W3

Authorized PLANNERA Signature _____ **Date (Month/Day/Year)** _____

Authorized PLANNERA Signature _____ **Date (Month/Day/Year)** _____

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