THE Great-West Life ASSURANCE COMPANY

GROUP LIFE INSURANCE
ADVANCE PAYMENT REQUEST FORM

Instructions:

- Complete this form when a terminally ill employee wishes to request an advance payment of a portion of his or her basic group life insurance benefit.
- Please answer all questions fully to avoid delays in processing this form. Indicate whether information does not apply, is unavailable or is unknown.
- If more space is required to answer any question, continue the answer on a separate sheet and attach it to this form.
- Submit this form, together with any additional sheets, to: Great-West Life
  Group Life Benefits 5W
  60 Osborne Street N
  Winnipeg MB R3C 1V3

Section 1 EMPLOYER INFORMATION

To be completed by employer - please print

Name of Employer				
Complete mailing address - Street	City	Province	Postal Code	Phone Number
Email address				Fax Number
Employer signature				Date

Section 2 EMPLOYEE INFORMATION

To be completed by employer - please print

Employee's Name				Date of Birth (YYYY/MM/DD)
Group Policy Number			Certificate Number	Division Number
Employee's Address - Street	City	Province	Postal Code	Employee's Phone Number
Email address			Amount of employee's basic life insurance benefit $	
Date of employment	Date last worked	Earnings as at last day worked $	Reason for leaving	

Section 3 BENEFICIARY INFORMATION

To be completed by employer - please print

Name (please enclose copies of all ***Application for Group Coverage*** and/or ***Group Coverage Change*** forms or beneficiary cards which contain beneficiary information).

Does the record indicate any beneficiary(ies) designated as irrevocable? ☐ Yes ☐ No

EMPLOYEE'S REQUEST AND RELEASE

To be completed by employee - please print

NOTE: An employee is eligible to request an advance payment of up to 50% of the employee's total basic group life insurance benefit or $50,000, whichever is less.

To be eligible for an advance payment, you must be suffering from a terminal illness and have a life expectancy of 24 months or less.

I certify that I am employed by _____, and have basic life insurance coverage under Group Policy No. _____(the "Policy") issued to _____ (the "Policyholder") by The Great-West Life Assurance Company; and

WHEREAS I am presently disabled and have been diagnosed as terminally ill; and

WHEREAS pursuant to the terms of the Policy, a basic life insurance benefit of $_____ is payable on my death; and

WHEREAS I hereby request that an immediate advance payment of my basic life insurance benefit be made to me in the amount of the lesser of 50% of my basic life insurance benefit and $50,000, which would otherwise be payable to my beneficiary(ies) or, in the absence of any beneficiary(ies), to my estate (the "Advance Payment"); and

WHEREAS I understand that the Advance Payment is not owing under the Policy and would be advanced by Great-West Life on the basis of compassionate grounds; and

WHEREAS I have agreed that interest at the rate of 2.90 percent per annum would be payable and would accrue with respect to the Advance Payment, from the date of the said Advance Payment to the date of my death, and that such interest would be simple interest and not compounded; and

WHEREAS I understand and agree that, if an Advance Payment is made, Great-West Life shall, at my death and subject to the condition that my basic group life insurance coverage under the Policy is in effect at the date of my death, pay to my beneficiary(ies), or in the absence of any beneficiary(ies), to my estate, an amount equal to the basic life insurance benefit payable under the Policy at my death less the Advance Payment and accrued interest; and

WHEREAS I understand and agree that should my basic life insurance coverage under the Policy terminate prior to the date of my death and after receiving the Advance Payment, Great-West Life may require me to pay back the Advance Payment together with interest accrued to the date of repayment.

WHEREAS I understand and agree that I will be solely responsible for any income tax liability which may occur as a result of the Advance Payment; and

NOW THEREFORE in consideration of Great-West Life providing me with the Advance Payment, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledge, I, _____, do hereby remise, release, acquit and forever discharge The Great-West Life Assurance Company and the Policyholder from any and all claims, debts, demands, actions or causes of actions which I, my heirs, administrators, executors, assigns or beneficiaries ever had, have or may have with respect to or in connection with the Advance Payment, and the interest accrued on the Advance Payment, which would otherwise be payable at my death under the Policy.

The preamble of this Request and Release is an integral part of this Request and Release and is not a mere recital.

I,_____ represent, warrant and certify that in executing this Request and Release, I do so with full knowledge of any and all rights which I may have under or in connection with the Policy.

IN WITNESS WHEREOF, I, _____ , have hereunto set my hand and seal

this _____ day of _____ , 20 _____ .

SIGNED, SEALED AND DELIVERED
In the Presence of:

WITNESS NAME (please print)	INSURED NAME (please print)
WITNESS SIGNATURE	INSURED SIGNATURE

PROTECTING YOUR PERSONAL INFORMATION

At **The Great-West Life Assurance Company**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices 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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

EMPLOYEE'S STATEMENT

To be completed by employee

To be eligible for an advance payment of your basic group life insurance, you must be suffering from a terminal illness and have a life expectancy of 24 months or less. After you have signed this statement below, your physician should complete the ***Attending Physician's Statement*** on the next page.

I expressly consent, authorize and direct any physician, surgeon or any other person who has examined me, and every hospital or other institution where I have received treatment to exchange with The Great-West Life Assurance Company or its duly authorized representatives any knowledge or information required for the purposes of assessing my request for an advance payment of my basic group life insurance. A photocopy of this authorization shall be as valid as the original.

Date _____ Signature _____

THE Great-West Life ASSURANCE COMPANY

ATTENDING PHYSICIAN'S STATEMENT
ADVANCE PAYMENT REQUEST

Return completed form to: Great-West Life
Group Life Benefits 5W
60 Osborne Street N
Winnipeg MB R3C 1V3

Physician Name	Telephone Number
Address	Email Address
Name of Insured	
Address: Street City Province Postal Code	Group Policy Number

The above named Insured has requested an advance payment of her or her Life Insurance proceeds due to a terminal illness. In order to provide consideration to the Insured's request, we require the following information:

Diagnosis: _____

If cancer, is it metastatic? ☐ Yes ☐ No What stage of cancer? _____

Is the Insured undergoing any treatment? ☐ Yes ☐ No

If yes, provide details: _____

Future Prognosis: _____

Life expectancy (survival rate): _____

Do you consider the Insured to be mentally competent/mentally able? ☐ Yes ☐ No

Please provide a description of the Insured's medical condition, including any complications, in the space provided below and attach **medical evidence to support the diagnosis**. (to be completed by a SPECIALIST physician if being followed by a specialist).

I certify the above information to be true and correct.

Date _____ Signature _____, M.D.

Clear