WESTERN CA SERVICES ASSOCIATION

10309C - 100 Avenue
Fort Saskatchewan, AB T8L 1Y9

APPLICATION FOR DEPENDENT CHILDREN LIFE INSURANCE
STATEMENT OF DEPENDENT'S HEALTH

1.

Eligible Dependents	Relationship	Date of Birth	Height in/cm	Weight lbs/kg

2. Have any of your dependents received treatment for, or had any medication prescribed for any ailment during the past 12 months? If yes, please give details below. ❑ Yes ❑ No

3. Have any of your dependents consulted or received treatment from a physician, physiotherapist, masseur, osteopath or chiropractor during the past 12 months? If yes, please give details below. ❑ Yes ❑ No

4. Are all of your dependents now in good physical and mental health and free from any physical defect or any symptoms of illness or disease? If no, please give details below. ❑ Yes ❑ No

Name of Dependent	Age	Nature of Illness

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organizations Institution or person, that has any medical records or medical knowledge of me or any of my dependents, who are proposed for insurance, to give the Great West Life Assurance Company or its reinsurer(s) any such information for the purpose of determining eligibility for the insurance applied for. A photographic copy of this authorization shall be as valid as the original.

I declare the above statements are true and complete and shall form part of the application for insurance.

Date: ____________________________

________________________________ ________________________________
Applicant Name (please print) Signature

Address ________________________________ City ________________ Postal Code _______