



Advisor code

Group long term disability insurance conversion

Your group long term disability insurance policy gives you the right to convert your group insurance to an individual policy without a medical examination when your group insurance ends. Your application for conversion of your long term disability is subject to Canada Life's underwriting rules for individual disability insurance, other than medical evidence or length of employment rules.

Instructions

- Print clearly using blue or black ink.
 - Fix errors by striking them out and having the person to be insured initial the change. We won't accept advisor initials.
 - Do not include a premium cheque with your application. We will advise you of the amount required after your application has been reviewed.
 - If you need more space to answer a question, write the information on a separate page and attach it to this application. Include the group policy number, question number, insured name, signature, and the date.
 - This application must be mailed and postmarked **within 31 days** from the start of your new job, but **within 6 months** from the end of your old job.
- Mail your completed application to:
The Canada Life Assurance Company
60 Osborne Street North, P.O. Box 6000
Winnipeg, MB R3C 3A5
Attention: Conversion Co-ordinator Group Policy Service
Email address: GMAA-Conversion@canadalife.com

1 The person to be insured

1.1 Information about the insured

First name	Middle name	Last name
Date of birth (day/month/year)	Apartment number	Street number and name, or P.O. box
City	Province	Postal code
Home phone	Business phone	Language ☐ English ☐ French
Email address		

2 Employment information

2.1 Previous employment information

Name of business or employer	
Group policy number	Date your group coverage terminated (day/month/year)

2.2 Current employment information

Name of business or employer		Occupation or title	
Business or employer address (street number and name)			
City	Province	Postal code	

2.3 Are you the owner of this business?

☐ Yes – how long have you been the owner:

☐ No – how long have you been employed by this business:

2.4 Duties	% of time	Describe duties
Administrative/office		
Manual/physical		
Supervision		
Sales		
Other (specify): 		

2.5 How many hours do you work per week: **How many weeks do you work per year:**

2.6 Does your new employer have a group insurance plan that includes long term disability coverage?

☐ Yes ☐ No

2.7 Do you have any disability income insurance or group long term disability coverage in force or pending?

☐ Yes – provide information below ☐ No

Insurance company	Type of insurance	Benefit period	Waiting period	Are the benefits taxable?	Monthly amount (\$)	Status of policy
	☐ Individual disability insurance ☐ Group long term disability coverage			☐ Yes ☐ No		☐ Awaiting approval ☐ In force Year issued: _____
	☐ Individual disability insurance ☐ Group long term disability coverage			☐ Yes ☐ No		☐ Awaiting approval ☐ In force Year issued: _____
	☐ Individual disability insurance ☐ Group long term disability coverage			☐ Yes ☐ No		☐ Awaiting approval ☐ In force Year issued: _____

2.8 Type of coverage you're applying for:

Monthly amount
\$

Benefit period

Waiting period

Your benefit waiting period can't be less than you have under your group policy. Certain occupational classifications may not be eligible for benefit periods to age 65.

2.9 Are you covered by employment insurance?

☐ Yes ☐ No

2.10 In your new job:**a) If you're an employee:**

What is your gross annual income including salary, wages, commissions, feed or other remuneration from employment such as bonuses, before taxes and excluding investment, rental and other un-earned income?

Per year
\$

b) If you're a self-employed business owner or proprietor:

What is your projected share of the business income less your share of the business expenses that are deductible under the Income Tax Act (Canada), before taxes?

Per year
\$

c) For incorporated business owners:

What is your projected earned income as determined in **2.10 a)** plus your share of the pre-tax profits?

Per year
\$

2.11 Have you smoked cigarettes in the last 12 months?

☐ Yes ☐ No

Agreements and signatures

You certify that the information is true, correct and complete to the best of your knowledge. You understand that no benefits will be payable for any claim prior to the end of the waiting period indicated in **2.8**.

Signed at (city or town, province)

Date (day/month/year)

Signature of **insured person**

X

Signature of **witness**

X

Name of **witness** (first, middle initial, last)



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