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 _____

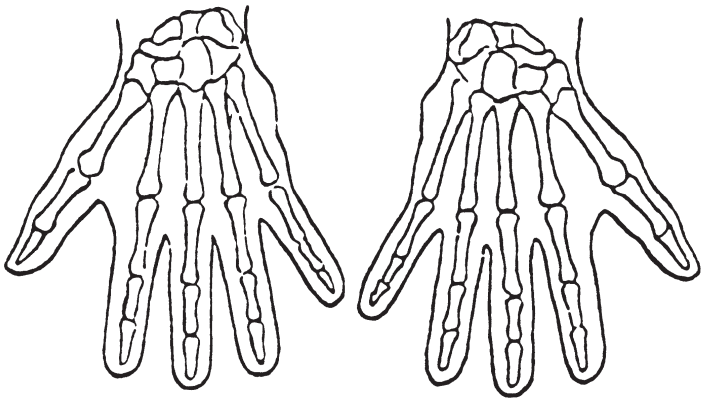
   (b) Briefly describe details of the accident. _____

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

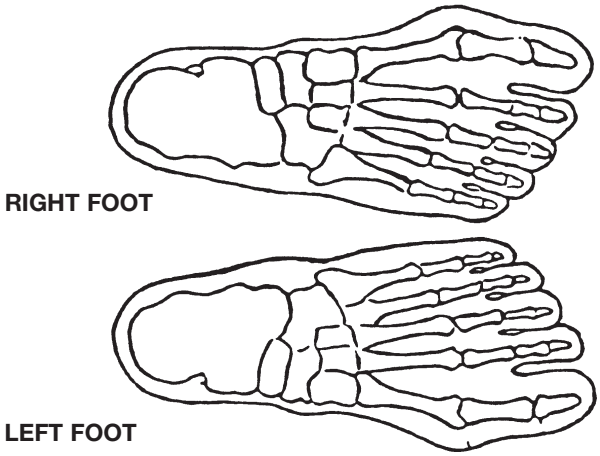
   (b) Date of most recent treatment. Month _____ Day _____ Year _____

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 _____

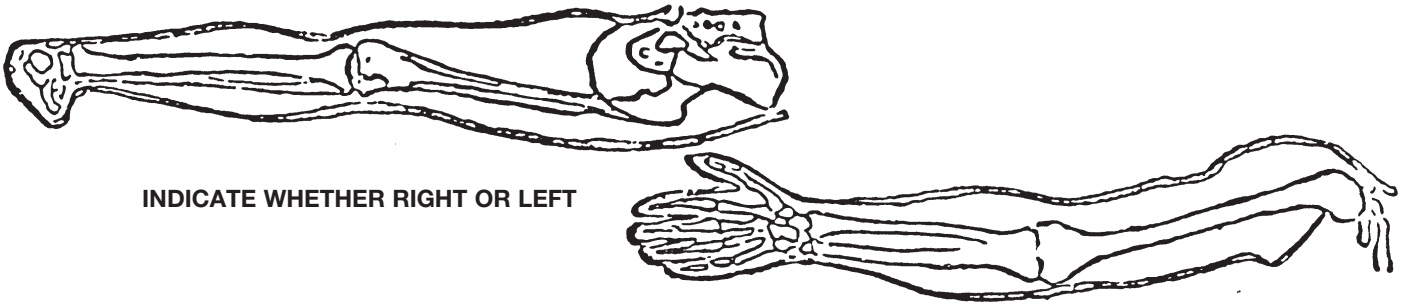


LEFT HAND RIGHT HAND



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 Canada Life, any healthcare provider, the 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 working with the deceased's plan administrator, within or outside Canada, to exchange personal information, when necessary to investigate and assess my claim, to administer the group benefits plan and to audit the assessment of the claim. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I have provided the information on this form in order to obtain payment of Group Life proceeds payable to me (in a personal capacity or on behalf of a beneficiary) and I hereby declare that I am legally entitled to receive all or a share of the proceeds payable under the Group Life Policy. I certify that by making payment to me, Canada Life has met its obligation to me. By signing below, I confirm that: I have read, understand and agree with the contents of this form and authorize Canada Life to collect, use, and disclose my personal information, all statements I have made about my claim are true and complete, my authorization is valid until I cancel it in writing, and a photocopy or electronic copy of this authorization is as valid as the original..

Signature _____ Date _____