GREAT-WEST FINANCIAL

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WAIVER OF PREMIUM PLAN 104GP Supplemental Member Statement

Member Name ADA# Cert# Claim#

Current Address

City State Zip Code Telephone Number

Progress

1. Has there been any change in your condition since your last report? ☐ Yes ☐ No
2. If yes, please explain the nature and extent of the change in condition:

_____

_____

_____

3. Briefly describe how your disabling condition impacts your daily activities:

_____

_____

Treatment

1. Please provide complete information about the physicians you have seen during the past 12 months.

Doctor's full name, address and telephone number:

_____

_____

_____

Date of your last visit: _____

Date of you next visit: _____

Condition being treated: _____

_____

Doctor's full name, address and telephone number:

_____

_____

_____

Date of your last visit: _____

Date of you next visit: _____

Condition being treated: _____

_____

2. Have you been hospital confined since your last report? ☐ Yes ☐ No
   If yes, please list name and address of hospital:

_____

_____

3. Condition being treated: _____

Date of Admission: _____ Date of Discharge: _____

1. Are you receiving Social Security benefits? ☐ Yes ☐ No

   (a) Have you applied? ☐ Yes ☐ No

   (b) Date of approval or denial: _____

2. Have you worked full-time or part-time during the past 12 months? ☐ Yes ☐ No
   If yes, please provide the date you returned to work and the job title:
   _____

3. Do you perform volunteer work? If so, please describe time involved and activities.
   _____
   _____

4. Are you handling your own business affairs? ☐ Yes ☐ No

I hereby certify that I have carefully read the foregoing questions and fully understand them, and that each answer is true and complete to the best of my knowledge and belief. I further understand Great-West (the Company) or its representative may request from time to time any documents which I have in my possession, supporting this statement, and I hereby agree to furnish them upon request. It is understood that the Company may make an independent investigation of this claim.

Authorization

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 organization, institution or person, having any records or knowledge of any illness, injury, medical history or treatment I have had, to furnish Great-West (the Company) all such information.

The information requested by the Company may include information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including consultations after the date this authorization is signed. Any other information the Company believes to be necessary to determine eligibility for insurance benefits may also be requested.

The information collected will be used for determining eligibility for benefits under any policies issued by the Company and for other business purposes in connection with the insurance relationship. All or part of the information collected may be sent to the Company's reinsurer's, and to other insurance companies with whom I have insurance or to whom I apply for insurance. Information may be sent to persons performing business or legal functions for the Company or to persons conducting research studies or audits.

This authorization shall continue to be valid for twelve months from the date it is signed. A photocopy of this signed authorization shall be as valid as the original. I may request a copy of this authorization.

State statutes in Idaho, New York, and Florida require the following language: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false of misleading information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in Florida, a felony of the third degree).

Print Name Signature* Date

***If this form is signed by someone other than the Insured, please provide name and relationship.**
(Please provide documentation showing who has legal Power of Attorney, unless this has previously been provided).