



# BASIC GROUP LIFE INSURANCE PREMIUM REMITTANCE FORM



**PLEASE COMPLETE IN DUPLICATE AND FORWARD ORIGINAL TO:**  
THE CANADA LIFE ASSURANCE COMPANY  
ATTN: PAYMENT ADMINISTRATION  
PO BOX 1053  
WINNIPEG MB R3C 2X4

NAME OF MEMBER ORGANIZATION	GROUP NUMBER <b>20484GLA</b>	DIVISION NO. S.H.A. CODE NO.	FOR THE MONTH OF
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**44989**

	BASIC LIFE INSURANCE		BASIC ACCIDENTAL DEATH AND DISMEMBERMENT		VOLUNTARY AD&D	
	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	SINGLE COVERAGE AMOUNT OF INSURANCE	FAMILY COVERAGE AMOUNT OF INSURANCE
1. IN FORCE COVERAGE THIS STATEMENT						
2. COVERAGE PREMIUM RATE		0.170 PER \$1,000		.020 PER \$1,000	.020 PER \$1,000	.040 PER \$1,000
3. PREMIUM DUE THIS STATEMENT (MULTIPLY ITEM 1 X ITEM 2)						
4. PLUS OR MINUS BACK PREMIUM ADJUSTMENTS						
5. TOTAL PREMIUM DUE THIS STATEMENT						

TOTAL PREMIUMS

DATE

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MISCELLANEOUS DEBIT OR CREDIT

SIGNING OFFICER

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**OUR CHEQUE PAYABLE TO THE CANADA LIFE ASSURANCE COMPANY IS ATTACHED.**

PHONE NUMBER

FAX NUMBER