



OPTIONAL NON-SMOKER RATE 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
 CANADA

NAME OF MEMBER ORGANIZATION	GWL ACCT. NO. ONLY 44989	DIVISION NO.	FOR THE MONTH OF
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CALCULATION OF PREMIUM DUE BY COVERAGE

IMPORTANT INCLUDE ALL CHANGES IN COVERAGE NOT PREVIOUSLY REPORTED AND EFFECTIVE ON OR PRIOR TO THE PREMIUM DUE DATE OF THIS STATEMENT	LIFE AGE UNDER 40		LIFE AGE 40 - 44		LIFE AGE 45 - 49		LIFE AGE 50 - 54		LIFE AGE 55 - 59		LIFE AGE 60 - 64	
	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	NO. OF EMPLOYEES	AMOUNT OF INSURANCE	NO. OF EMPLOYEES	AMOUNT OF INSURANCE
1. IN FORCE COVERAGE (FROM LINE 6 PREVIOUS STATEMENT)												
2. PLUS ADDITIONS (NEW ENTRANTS, REINSTATEMENTS, TRANSFERS IN)												
3. PLUS INCREASES IN COVERAGE												
4. MINUS CANCELLATIONS (TERMINATIONS, DEATHS, TRANSFERS OUT)	—	—	—	—	—	—	—	—	—	—	—	—
5. MINUS DECREASES IN COVERAGE												
6. IN FORCE COVERAGE THIS STATEMENT (NET TOTAL OF ITEMS 1 TO 5)												
7. COVERAGE PREMIUM RATE	.044 PER \$1,000		.075 PER \$1,000		.106 PER \$1,000		.250 PER \$1,000		.425 PER \$1,000		.594 PER \$1,000	
8. IN FORCE PREMIUM THIS STATEMENT												
9. PLUS BACK PREMIUM CHARGES												
10. MINUS BACK PREMIUM CREDITS												
11. TOTAL PREMIUM DUE THIS STATEMENT												

TOTAL OF LINE 11 ALL PREMIUMS \$ _____

MISCELLANEOUS DEBIT OR CREDIT \$ _____

OUR CHEQUE ATTACHED IN THE AMOUNT OF \$ _____

DATE _____

SIGNING OFFICER _____