Application for Optional Coverage Form

Please return this completed form and supporting documents to:

The Wawanesa Life Insurance Company
Group Benefits Services
236 Carlton Street, Winnipeg, Manitoba R3C 1P5
For Inquiries, please call 1-800-665-7076

This form is used to apply for Optional Life, Optional Accidental Death & Dismemberment, and/or Optional Critical Illness coverage for a Plan Member and their Spouse, and/or dependent child(ren).

Important Information

- Please answer all questions to avoid delays in your application.
- Section 1 is to be completed by the Plan Sponsor; sections 2-7 are to be completed by the Plan Member.
- Evidence of insurability is required in some cases. Please carefully review section 5 of this form to determine if you are required to provide evidence of insurability to avoid delays in your application.
- Coverage requiring evidence of insurability is not effective unless and until you receive notice of approval from Wawanesa Life.
- In this form, 'you', 'your' and 'I', refer to the person applying for insurance.
- Once complete please email your application to grpspecialists@wawanesa.com or mail it to the address above.
- If you have any questions regarding your application for Optional Coverage please contact your Plan Administrator.

1. Plan Sponsor Section (This section to be completed by the Plan Sponsor)

Plan Number: ____________________ Plan Sponsor Name: ____________________

Account Number: ____________________ Class: ____________________ Plan Mamber ID: ____________________

Group Insurance Plan Coverage Effective Date (dd/mm/yyyy): ____________________ Hire Date (dd/mm/yyyy): ____________________

Occupation: ____________________

2. Plan Member Information

Last Name: ____________________ First Name: ____________________

Date of Birth (dd/mm/yyyy): ____________________ Sex: ○ Male ○ Female

Phone Number: ____________________ Email: ____________________

Street Address: ____________________

City: ____________________ Province: ____________________ Postal Code: ____________________

3. Optional Coverage Selection

Please complete the following in this section:

1. Enter previously approved coverage amounts in the “Current Optional Coverage Amount” section as it will assist you in determining your total optional coverage,
2. State the amount of coverage you are currently applying for, whether it’s new coverage or adding on to existing optional coverage, in the “Additional Optional Insurance Amount Requested” field,
3. Confirm the total optional coverage amount does not exceed the maximum stated in your employee booklet, and
4. Ensure the amount of coverage being applied for is in the units of coverage stated in your employee booklet.

Optional Life	Current Optional Coverage Amount	Additional Optional Insurance Amount Requested	Total Optional Coverage
Plan Member			
Spouse / Partner			
Dependent Child			

Optional Accidental Death & Dismemberment	Current Optional Coverage Amount	Additional Optional Insurance Amount Requested	Total Optional Coverage
Plan Member			
Spouse / Partner			
Dependent Child			

Optional Critical Illness	Current Optional Coverage Amount	Additional Optional Insurance Amount Requested	Total Optional Coverage
Plan Member			
Spouse / Partner			
Dependent Child			

4. Smoking Declaration

In the past 12 months, have you used any tobacco or nicotine products including cigarettes, cigarillos, colt, cigars, pipes chewing tobacco, snuff, nicotine gum or patches, e-cigarettes, vaporizers, or any for of nicotine substitute?

Plan Member: ◯ Yes ◯ No

Plan Member’s Signature: ______________________________ Date of Signature (dd/mm/yyyy): ____________________

Spouse (if applicable): ◯ Yes ◯ No

Spouse’s Last Name: ______________________________ Spouse’s First Name: ______________________________

Date of Birth (dd/mm/yyyy): ______________________________ Spouse’s Signature: ______________________________

5. Evidence of Insurability

With regard to Optional Life and/or Optional Critical Illness coverage, you and/or your dependent(s) are required to complete an **Evidence of Insurability** form if: (A) the amount of Total Optional Coverage you and/or your dependent(s) are applying for (including Current Optional Coverage previously applied for) exceeds the Non-Evidence Maximum amount specified in your Plan Member booklet; or, (B) if you and/or your dependent(s) are applying for Optional Life and/or Optional Critical Illness coverage beyond 60 days of becoming eligible for the Optional coverage. If required, please complete and submit your and/or your dependent(s)' completed **Evidence of Insurability** form(s) along with this **Application for Optional coverage** to grpspecialists@wawanesa.com or mail it to the address provided on page 1 of this form.

All group forms and resources can be found on our website: https://www.wawanesalife.com/group-insurance/forms-and-resources/

6. Beneficiary Designation for Optional Coverage (the Plan Member reserves the right to change the beneficiary)

Designated beneficiary(ies) for all eligible optional coverage will be the same as the designated beneficiary(ies) for the applicable individual's current Group Life Insurance coverage under this plan. Should you wish to change your beneficiary designation, please complete and mail a **Beneficiary Form** to P.O. Box 1640, Windsor, ON N9A 0C8.

All group forms and resources can be found on our website: https://www.wawanesalife.com/group-insurance/forms-and-resources/

7. Consent, Disclosure, Authorization and Acknowledgement

Consent & Disclosure Regarding Personal Information

I consent to The Wawanesa Life Insurance Company ("Wawanesa Life") collecting, using and disclosing my personal information for the purposes of: establishing and maintaining communications with me; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law.

I understand that Wawanesa Life may share my personal information with the following: Wawanesa Life employees and agents who require this information to perform their jobs; claims investigators, investigative agencies, regulatory bodies, providers of information processing and storage, and distribution services; applicable insurance/reinsurance companies; applicable health care providers, people to whom I have granted access; and people who are legally authorized to view my personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada and I understand my information may be shared as required by the laws of those jurisdictions.

If you have questions concerning the collection, use, disclosure or storage of personal information or a concern regarding our privacy policies or procedures, please review the privacy policy found here https://www.wawanesalife.com/pip/privacy.html or contact the Privacy Officer, privacy@wawanesa.com, 1-844-241-0226 or by mail: The Wawanesa Life Insurance Company, 236 Carlton St, Winnipeg, MB, R3C 1P5.

Authorization & Acknowledgement

- I hereby apply for coverage for which I am, or may become eligible under the Group Insurance Plan issued by Wawanesa Life.
- I acknowledge and agree that I will only enroll, at this time or any future time, dependents who have authorized me to provide their information and consent to the collection, use and disclosure of that information for the purposes listed above.
- I confirm that the information provided in this form is complete and accurate.
- I, the Plan Member, authorize the deduction from my pay of any contributions required under the Group Insurance Plan.
- I authorize Wawanesa Life, any healthcare provider, my plan administrator, other insurance companies, and/or benefit providers working with Wawanesa Life to exchange information when necessary to determine my eligibility for coverage and to administer the Group Insurance Plan.
- I understand that concealment, misrepresentation or false declaration concerning the information in this form may cause the insurance coverage to be void.
- I acknowledge that I have read the Consent & Disclosure regarding personal information and consent to my personal information being used in such a manner.

Submission of a photocopy or electronic copy of this application form will be as valid as the original.

Plan Member Signature	Date of Signature (dd/mm/yyyy)

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