Group Operation
P.O. BOX 1640, Windsor, ON N9A 0C8
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Alternate Coverage Information

EMPLOYER/EMPLOYEE IDENTIFICATION

Policy #_________________ Plan Sponsor Name ____

Plan Member Name ____ Plan Member ID# __________________
Last Name First Name

This form must be completed in conjunction with the Notice of Change form to ensure full details of dependents are provided.

☐ Alternate coverage has now terminated. Coverage under Wawanesa Plan for Health, Vision and/or Dental Benefits was previously waived.

☐ Alternate coverage is still in effect. Application is being made to Wawanesa Life to provide additional coverage.

Coverage required for: Health ☐ Vision ☐ Dental ☐

The following information is required to apply for coverage at this time:

1. The reason the Plan Member and/or their dependents are no longer covered under an alternate policy.

2. The date that the alternate coverage terminated.

3. The name and address of the Plan Sponsor where alternate coverage was provided (if covered through a plan at work).

4. The insurance company name and the policy number of the terminated or alternate plan(s).

5. Benefits that the Plan Member and/or their spouse had through the terminated plan:
   - ☐ Health
   - ☐ Vision
   - ☐ Dental ______________________________
   - ☐ Other (List): ______________________________

______________________________ ______________________________

Signature of Plan Member Date

For Wawanesa Life Executive Office Use Only

Alternate Coverage Terminated/COB Updated Date: ______________________

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