Please return this completed form and supporting documents to:

Wawanesa Life - Claims
236 Carlton St, Winnipeg, MB R3C 1P5
For inquiries, please call: 1-844-318-0411, #3
Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

CRITICAL ILLNESS
- PLAN MEMBER'S STATEMENT

PLAN MEMBER INFORMATION

Plan Sponsor_____ Group Plan #_____

Plan Member_____ Date of Birth_____
Last Name First Name Initial (yy/mm/dd)

Address_____
Street City Province Postal Code

Phone Number_____ Email_____

I authorize the use of my Social Insurance Number for tax reporting purposes when required in payment of my Group Critical Illness benefit.

Social Insurance Number_____ Signature_____

MEDICAL INFORMATION

Describe nature and severity (including diagnosis) of your illness:

Date of Diagnosis:_____

Date symptoms first appeared:_____

Describe symptoms experienced at onset:

Date first consulted a medical practitioner in connection with your illness; include name, address and specialty of medical practitioner consulted:

Indicate nature of tests and investigations performed, including dates. If no tests or investigations performed, why not?

Have you previously suffered from, or received treatment for a similar or related illness? ☐ Yes ☐ No

If 'Yes', provide details including dates:

TREATMENT INFORMATION

Names and address of your treating physician; include date of last visit:

List all medical practitioners consulted in connection with your illness:

Name of Medical Practitioner	Specialty	Address	Date Last Seen

TREATMENT INFORMATION

Continued

Detail treatment received including, surgery, medication, therapy, etc.:

Type of Treatment	Details: frequency, dosage, date of surgery/procedure, etc.

If hospitalized, please list:

Name of Hospital	Reason	Date of Admission	Date of Discharge

OTHER INFORMATION

Will you be claiming for benefits related to this illness from any other company? ☐ Yes ☐ No

If 'Yes', please indicated name of company and type of benefit:

Use this space and the reverse of this form to provide any additional information you feel may be helpful.

Authorizations and Declarations

AUTHORIZATIONS

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering my Critical Illness claim.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during my claim under this policy, with the insurer's reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

I understand that by furnishing this form and investigating the claim or by accepting Proofs of Claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the plan.

CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

I consent to 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 people, organizations and service providers: Wawanesa Life employees who require this information to perform their jobs; claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies; 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. My information may be shared as required by the laws of those jurisdictions. I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the claim being applied for.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from www.wawanesalife.com or from our Customer Service Department, Wawanesa Life, 236 Carlton St, Winnipeg, MB R3C 1P5.

If you have a question (including a question concerning our collection of personal information or the collection, use, disclosure or storage of personal information by service providers outside Canada on our behalf) or complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance: Privacy Officer, The Wawanesa Life Insurance Company, 236 Carlton St, Winnipeg, MB R3C 1P5.

DECLARATION AND SIGNATURE

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from Wawanesa Life and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended me and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting me for the purpose of administering my Critical Illness claim.

A photocopy or an electronic reproduction of this document will be as valid as the original.

WLI# _____
Plan Member ID#

_____
Plan Member's Name (Print)

_____
Date (yy/mm/dd)

_____
Plan Member's Signature