Group Operation
PO Box 1640, Windsor, ON N9A 0C8
1-800-665-7076

Essentials Basic & Enhanced Employee Application

A. INFORMATION SUPPLIED BY PLAN SPONSOR

Date Employed	Plan Sponsor Name	Policy #	Class #
_____ (YY/MM/DD)	_____ *Employee must receive a T4 from this Policyholder.*	_____	_____

Coverage Effective Date	Plan Member Occupation	Number of Hours worked per week	Earnings
_____ (YY/MM/DD)	_____	_____	$ _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

B. PLAN MEMBER INFORMATION · Please Type or Print Clearly

Plan Member Name _____

Mailing Address _____ Street _____ City _____ Province _____ Postal Code

ID # (new employee to be assigned) _____ Language ☐ English ☐ French Province of Employment _____

Date of Birth	Sex		
_____ (YY/MM/DD)	☐ Male ☐ Female	Do you have a spouse*?	☐ Yes ☐ No
		Do you have dependent child(ren)? (Under 21 years of age)	☐ Yes ☐ No
		Ages 21-25 attending school full time* *Submit a completed Dependent Child Eligibility form for each child	☐ Yes ☐ No

*Common-Law spouse eligible after 12 months of co-habitation Date of Co-habitation: _____

C. DEPENDENT INFORMATION Please indicate any or all of the following that apply:

☐ I require Single coverage.
I have no dependents.

☐ I require Single coverage.
My dependents are covered under another plan.

Carrier Name_____

Plan#_____

☐ I require Family coverage.
Coverage for myself and dependents.

☐ I wish to co-ordinate my coverage with my spouse's plan.

Carrier Name_____

Plan#_____

	Last Name	First Name	Initial	Sex	Birth Date YY/MM/DD
Spouse					
1st Child					
2nd Child					
3rd Child					
4th Child					
5th Child					

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Policy # _____ **Plan Member Name** _____ _____
Last Name **First Name**

D. BENEFICIARY DESIGNATION

Beneficiary's Name(s) ☐ **New** ☐ **Change**

Last Name	First Name	Initial	% Allocated	Relationship of Beneficiary to Applicant
Total			**100%**	

The Plan Member can designate or change a beneficiary at any time. Please note that designating a beneficiary is one of the most important decisions you will make regarding this Group Insurance Plan. The Designations that you make should clearly reflect your intentions of who will receive the death benefit proceeds.

You can designate a **Contingent Beneficiary** by attaching a separate page to this application with your instructions and signature.

When percentages have been allocated to each beneficiary, only these amounts can be paid to each beneficiary. Should one of the beneficiaries die before you, his/her portion would be made payable to your estate.

If you are designating a beneficiary who is a minor, insurance proceeds cannot be paid directly to him/her. In order to avoid difficulties with settlement of a claim, a trustee should be named for all minor children. **Please complete the Trustee Designation.**

E. PLEASE NOTE: The Trustee Designation is ONLY to be completed when a Named Beneficiary is a minor

Trustee Designation: I hereby appoint _____ _____
Name Relationship

as trustee to receive any payments on behalf of , the beneficiary that I have designated during his/her minority.

F. NOTICE OF CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION – AUTHORIZATION AND ACKNOWLEDGEMENT

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 and agents 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 acknowledge that I 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 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 the Wawanesa Life Executive Office at 236 Carlton St, Winnipeg MB, R3C 1P5 or at www.wawanesalife.com.

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.

- I hereby apply for coverage for which I am, or may become eligible under the Group Insurance Plan issued by Wawanesa Life.
- I acknowledge that the information provided is complete and accurate.
- I authorize the deduction from my pay for any contributions required under the Group Insurance Plan, if required.
- I authorize Wawanesa Life, or any healthcare provider, my plan administrator, other insurance companies, or benefit providers working Wawanesa Life to exchange information, when necessary to determine my eligibility for coverage and to administer the Group Insurance Plan.
- I acknowledge that I have read the Consent & Disclosure regarding Personal Information and consent to my personal information being used in such manner.

Date _____ Signature _____