Wawanesa Life®

Please Indicate:

☐ New Plan Member ☐ Reinstatement

Group Benefits

Enrollment -Application

Group Operation

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

A. INFORMATION SUPPLIED BY PLAN SPONSOR

Date of Hire	Plan Sponsor Name	Account Name & Number	Class
_____ (YY/MM/DD)	_____	_____	_____

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

For Wawanesa Life Executive Office Use Only

W.P. Eff. Date R.C.

B. PLAN MEMBER INFORMATION

Please Type or Print Clearly

Policy # _____ Plan Sponsor Name _____

Plan Member Name _____ (Last Name) _____ (First Name)

Mailing Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

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

Date of Birth _____ (YY/MM/DD) Sex ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Common-Law* ☐ Separated

Do you hold a valid Provincial Health Card? ☐ Yes ☐ No

* Commencement Date of Common-Law Relationship: _____ (YY/MM/DD)

C. DEPENDENT INFORMATION List all eligible dependents below: (If coverage is not required, please complete Part D Waiving of Extended Health and/or Dental Benefits)

Important: All dependents MUST be listed below to be enrolled for Dependent Life coverage if applicable

	Last Name	First Name	Initial	Sex	Birth Date Year Month Day
Spouse					
1st Child					
2nd Child					
3rd Child					
4th Child					

Other Insurance: Co-ordination of Benefits ☐ Yes ☐ No

If your family members have insurance coverage under any other plan providing similar benefits, your benefits will be coordinated with the other plan(s). Claims will be coordinated according to industry guidelines so that the total payments under all plans do not exceed 100% of the total eligible expenses.

In situations of divorce or separation, the plan of the parent with custody of the child will assess claims first.

My spouse has the following group benefits coverage through a different insurance plan:

Health	Single ☐	Family ☐	None ☐
Vision	Single ☐	Family ☐	None ☐
Dental	Single ☐	Family ☐	None ☐

D. WAIVING OF EXTENDED HEALTH AND/OR DENTAL BENEFITS

I have been offered the opportunity to join the Group Insurance Plan and the benefits provided by this Plan have been explained to me. However, I choose to waive the following benefits:

Important: *Coverage can only be waived for the benefits below if you and/or dependents are covered by similar group benefits through your spouse's employer.*

I waive Extended Health for:	**I waive Vision for:**	**I waive Dental for:**
☐ Myself and my dependents ☐ My dependents ONLY	☐ Myself and my dependents ☐ My dependents ONLY	☐ Myself and my dependents ☐ My dependents ONLY

Name of Spouse's Insurer _____ Plan Number _____

If you lose spousal coverage, you **must** apply for coverage under this Plan within 31 days of loss of such coverage.
If you apply for coverage after the 31 days, you may be required to provide evidence of insurability and your dental benefits will be restricted.

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

E. BENEFICIARY DESIGNATION (the Plan Member reserves the right to change the beneficiary)

Beneficiary's Name(s)

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

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.**

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 beneficiaries listed above during their age of minority.

F. 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 people, organizations and service providers: 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, 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.

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 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, any healthcare provider, my plan administrator, other insurance companies, 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 acknowledge that I have read the Consent & Disclosure regarding Personal Information and consent to my personal information being used in such a manner.

Date_____ Signature _____
(YY/MM/DD)