



Group Division
400 – 200 Main Street, Winnipeg, MB R3C 1A8

Late Application for Group Insurance

INSTRUCTIONS

1. Please complete all sections of the form.
2. Please sign and date your application.
3. Please remove the "Notice of Medical Information Bureau" on Page 4. This should be kept for your information.
4. To ensure that the information contained in this form is treated in a confidential manner, please send your completed application directly to Wawanesa Life at the address listed below.
5. If further information is required, we will be in contact with you directly.
6. All information provided by you is located at our Head Office:

The Wawanesa Life Insurance Company
Group Division
400 – 200 Main Street
Winnipeg, MB R3C 1A8

Who is completing this application? (please complete one of the following)

Employee – please provide:

Last Name First Name Initial Certificate Number

Spouse – please provide:

Last Name First Name Initial

Employee Name Certificate Number

Dependent Child – please provide:

Last Name First Name Initial

Employee Name Certificate Number

For Wawanesa Life Head Office Use Only:

Underwriting	Life	Dependent Life	STD	LTD	EHB/Vision	Dental
Amount						
Decision						

Comments:

EMPLOYER/EMPLOYEE IDENTIFICATION

Name of Employer _____ **Group #** G

Name of Applicant _____ **Date of Birth** _____

Last Name First Name Year Month Day

Home Address

Street & Number City Province Postal Code

Phone Numbers: Home _____ Bus. _____

Occupation (give details of duties) _____ **Place of Birth** _____

Province Country

PERSONAL INFORMATION – PART 1

1. Name of personal physician _____ Physician's phone no. _____

Address of Personal Physician _____

Street & Number City or Town Province Postal Code

2. (a) Height ____ Ft. ____ ins. (b) Current Weight _____ lbs. (c) Weight Gain ____ Weight Loss ____ In the past year.

3. Have you used any tobacco or nicotine products including cigarettes, cigarillos, colts, cigars, pipes, chewing tobacco, snuff, nicotine gum or patches or any form of nicotine substitute in the last 12 months? Yes No If 'Yes', how much? _____

4. (a) Do you presently use alcoholic beverages? Yes No If 'Yes', how much? _____

(b) Have you ever received treatment or been advised to seek treatment or medical advice because of your alcohol usage? Yes No

5. (a) Are you now using or have you ever used illicit drugs? Yes No

If 'Yes', please specify the drug(s), quantity, frequency of use and date(s) used. _____

(b) Have you ever received treatment or been advised to seek medical treatment because of drug usage? Yes No

6. (a) Have you ever had your Driver's License suspended or revoked? Yes No

(b) Have you ever been charged with driving while impaired or, within the last 10 years been charged with reckless driving or had more than 3 driving violations? Yes No

7. Do you currently participate in any hazardous sport activity, such as SCUBA diving, piloting aircraft, sky diving, auto racing, etc.? Yes No

If 'Yes', please specify which activity and how often. _____

8. Have you:

(a) ever applied for or received benefits, compensation or pension because of sickness or injury? Yes No

(b) ever had an application for life or health insurance declined, postponed, or modified in any way? Yes No

(c) been absent from work for more than 7 consecutive days for medical reasons during the last 5 years? Yes No

(d) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment? Yes No

9.

Question Number	Please provide additional relevant information to all 'Yes' answers above

PERSONAL INFORMATION – PART 2

FOR QUESTIONS ANSWERED 'YES', CIRCLE THE APPROPRIATE DISORDER AND GIVE DETAILS IN SECTION 15.

10. Has any family member (whether now living or deceased) ever suffered from, or is suffering from High Blood Pressure, Heart Disease, Stroke, Cancer or any other tumour (specify type of cancer or tumour), Diabetes, Polycystic or other Kidney Disease, Mental Illness, Huntington's Disease, Motor Neuron Disease (including ALS/Lou Gehrig's Disease), Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease? Yes No

Please complete the following chart for ALL family members:

	Disease	Age at Diagnosis	Actual Age, if alive	Condition, if alive	Age at Death	Cause of Death
Father						
Mother						
Brother (1)						
Brother (2)						
Sister (1)						
Sister (2)						

11. Have you ever been treated for, been advised to seek advice or treatment for, or had any known indication of, or any disorder of:

(a) **The Ears, Eyes, Nose, Throat, Lungs:**
including blood spitting, tuberculosis, pleurisy, shortness of breath, persistent cough, asthma, bronchitis, impairment of hearing, speech or sight? Yes No

(b) **The Heart, Arteries or other parts of the Circulatory System:**
including angina, chest pain, elevated cholesterol, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, peripheral vascular disease, or abnormal ECG ? Yes No

(c) **The Abdominal Organs:**
including ulcer, hernia, colitis, gallstones, Crohn's disease, diverticulitis, hepatitis, jaundice, liver disease, chronic diarrhea, pancreatic disease or intestinal polyps? Yes No

(d) **The Kidneys, Bladder, Genital Organs:**
including blood or pus or sugar or albumin in urine, stones, sexually transmitted disease or prostate disease? Yes No

(e) **The Brain and Nervous System:**
including epilepsy, seizures, convulsions, stroke, transient ischemic attack (TIA), multiple sclerosis, numbness or tingling of limbs, dizziness or fainting spells, paralysis, Alzheimer's, Parkinson's, Huntington's, motor neuron disease (including ALS/Lou Gehrig's disease), coma, head injury, persistent headaches, nervous breakdown, emotional or nervous disorder? Yes No

(f) **The Blood and Glands:**
including anemia, diabetes, leukemia, gout, allergy, night sweats, enlargement of lymph nodes (glands), breast disorder, thyroid disorder, unusual skin lesions or disorders or unexplained infections? Yes No

(g) **The Musculo-Skeletal System:**
including arthritis, ruptured disc, back or neck pain, knee problems, whiplash, rheumatism, lupus, paralysis, deformity, amputation or any other disease, injury or deformity of the spine, joints, bones or muscles including fibrositis or fibromyalgia? Yes No

(h) **The Immune System:**
including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (A.R.C.), positive HIV test or any other immunological disorder? Yes No

(i) Cysts, tumours, cancer, polyps, mole, lump or other growths, breast disorder or unusual discharge or abnormal mammogram or biopsy? Yes No

12. Other than as disclosed in the answers above, have you:

(a) Consulted a doctor or medical practitioner within the last 5 years? Yes No

(b) Had an ECG, blood tests or other diagnostic tests in the last 5 years? Yes No

(c) Ever been tested for exposure to the AIDS virus? Yes No

(d) Have you ever been advised to have any diagnostic test, hospitalization, or surgery which has not been completed? Yes No

13. Are you currently under any treatment or medication? Yes No

14. Has there been any change in your name in the last 5 years (marriage, etc)?
If 'Yes', please give previous names in Section 15. Yes No

PERSONAL INFORMATION – PART 2 (continued)

USE THE FOLLOWING SECTION FOR DETAILED INFORMATION TO YES ANSWERS ON PART 2 OF THIS APPLICATION

Question Number	Details as to diagnosis, Duration and results	Date	Name and Address of Physician and/or Hospital

CONSENT, DISCLOSURE, AUTHORIZATION & ACKNOWLEDGEMENT

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 recognize that in providing service to me in the future and providing me with the benefits included in the Group Benefits Plan I am enrolling in, Wawanesa Life may need to collect, use and disclose additional personal information about me. I confirm that this consent applies to that personal information as well.

You may obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 400 – 200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com

Authorization & Acknowledgement

I hereby apply for group insurance under the group insurance policy issued to my employer or my spouse's employer by The Wawanesa Life Insurance Company, and agree that the insurance will not commence until this application is approved by The Wawanesa Life Insurance Company.

I hereby acknowledge that the answers recorded are given by me and are complete and true. They shall be part of any contract issued by The Wawanesa Life Insurance Company.

I acknowledge receipt of the notice regarding the Medical Information Bureau and Investigative Reports, and consent to such reports being obtained by Wawanesa Life.

I authorize any licenced physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, Motor Vehicle Department concerning driving records, or other organization, institution or person that has any records or knowledge of me or my health to give Wawanesa Life or its reinsurer(s) any such information.

I authorize Wawanesa Life to perform such tests, examinations, x-rays, electrocardiograms, urinalysis, general blood profiles including blood tests for AIDS as may be required to medically underwrite this application for insurance. I authorize the Medical Director of Wawanesa Life to release all medically related information obtained during the underwriting process to my personal physician or other medical practitioner.

A photographic copy of this authorization shall be as valid as the original.

Date _____ Signature of Applicant _____

This form must be completed and received in our office within 60 days of the above date. Otherwise, a new form must be completed.



**This notice must be detached and given to the Applicant
NOTICE OF MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Wawanesa Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7.

Wawanesa Life, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

In the processing of the application for insurance, the Wawanesa Life Insurance Company may obtain Motor Vehicle Reports, a personal investigation or consumer reports containing personal information about the applicant.