



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

**Group Benefits
Enrollment – Voluntary Application**

Please Indicate: New Employee Reinstatement

A. EMPLOYEE INFORMATION Please Type or Print Clearly

Policy # G Employer Name _____

Employee Name _____
First Name _____ Last Name _____

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

Date of Birth _____ Sex Male Female Marital Status Married Single Widowed
 Divorced Common-Law Separated

B. DEPENDENT INFORMATION
List all eligible dependents below: (If coverage is not required, please complete Part C. Refusal of Benefits)

	Last Name	First Name	Initial	Sex	Birth Date			*Other Insurance	
					Year	Month	Day	Health	Dental
Spouse									
1 st Child									
2 nd Child									
3 rd Child									
4 th Child									
5 th Child									

***Other Insurance: Co-ordination of Benefits**
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.

You must declare other coverage by completing the Other Insurance columns for dependents covered under another plan.

If your spouse has other coverage, place an S (Wawanesa plan is considered the Secondary plan) in the Other Insurance column.

For dependent children eligible under your spouse's plan, place an S if your date of birth falls later in the year than the date of birth of your spouse. (e.g. If your date of birth is in June and your spouse's date of birth is in March – place an S in the Other Insurance Column)

In situations of divorce or separation, if you have custody of a dependent child, the Wawanesa plan will be considered the Primary (first) plan. If you do not have custody, and other insurance coverage exists for this child, place an S in the Other Insurance column. (The plan of the parent with custody of the child will be the Primary plan).

C. REFUSAL OF BENEFITS

I have been offered the opportunity to join the firm's Group Insurance Plan and the benefits provided by this Plan have been explained to me. However, I **decline** to participate in the following benefits:

I decline Extended Health for: Myself and my dependents **I decline Dental for:** Myself and my dependents
 My dependents ONLY My dependents ONLY

Note: Coverage can only be refused for the above benefits if you and/or dependents are covered by similar group benefits through your spouse's employer.

Spousal Insurer's Name _____ Plan Number _____

I decline to participate in ALL BENEFITS. Please date and sign below to indicate your refusal to participate in the Group Insurance Plan.

Date _____ Signature _____

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.

D. INFORMATION SUPPLIED BY POLICYHOLDER

Date Employed	Employer Name	Account Name & Number	Class
_____	_____	_____	_____
Effective Date	Employee Occupation	Number of Hours worked per week	Earnings
_____	_____	_____	\$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually

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Policy # G Employee Name _____
Last Name First Name

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

Beneficiary's Name(s)				
Last Name	First Name	Initial	% Allocated	Relationship of Beneficiary to Applicant
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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.

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.

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.

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 received any payments on behalf of _____, the beneficiary that I have designated during his/her minority.

F. CONSENT, DISCLOSURE, AUTHORIZATION AND 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.

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.

You can 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 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.

Date _____ Signature _____

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