

Plan Member Statement Accident Benefit Plan



Please return this completed form and supporting documents to:

The Wawanesa Life Insurance Company

Attn: Life Claims Department
236 Carlton Street, Winnipeg, Manitoba R3C 1P5
For inquiries, please call 1-844-318-0411
Fax: 1-855-496-3028 Email: wawanesalife-claims@wawanesa.com
wawanesalife.com

Plan Member Information

First Name: _____ Last Name: _____ Date of Birth (mm/dd/yyyy): _____

Gender: Female Male Transgender Non-Binary/Non-Conforming Undisclosed

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Preferred Telephone Number: _____ Home Work Cell

Email: _____

Language Preference: French English Other

If other, do you require an interpreter for verbal and/or written communication? Yes No

Language Required: _____

Claim Submission Details *Are required*

Who is the benefit for? Employee/Member Spouse

If spouse selected, Full Name: _____ Date of Birth (mm/dd/yyyy): _____

Select all that apply:* Weekly Accident Indemnity Accidental Dental Expense Accidental Dismemberment/Loss of Use
 Reimbursement Expense Predetermination Expense

*Please refer to your benefits booklet or connect with your Plan Sponsor to determine eligible coverage

If you are applying for a Weekly Accident Indemnity, provide the following information:

Last day worked (mm/dd/yyyy): _____ Hours worked the day before disability: _____

Have you returned to work? Or are you planning on returning to work? Yes No Provide date (mm/dd/yyyy): _____

Details of Claim

Please describe your condition:

What are your restrictions and when did they begin?

Where did you sustain an injury as the result of an accident? _____

Time and date of accident: _____

Was another party involved? Yes No

Was it reported to the police? Yes No

Were any charges laid? Yes No

Plan Member Treatment Information

Were you admitted to a hospital? Yes No

If yes, Admission date (mm/dd/yyyy): _____

Discharge date (mm/dd/yyyy): _____

List all health care providers you have consulted (e.g. Chiropractor, Physiotherapist, Doctor etc.)

Name	First Consultation (mm/dd/yyyy)	Last Consultation (mm/dd/yyyy)	Reason for consultation

List your treatment including medications

Treatment	When treatment started (mm/dd/yyyy)	Reason for treatment	Any changes in treatment (i.e. dosage, type of therapy, etc.)	Date of change (mm/dd/yyyy)

Reimbursement for Treatment due to an Injury as the result of an accident

Are you applying for reimbursement of expenses? Yes No

If yes, receipts are required: Enclosed Will be submitted

Are you receiving ongoing treatment? Yes No If yes, expected duration of treatment? _____

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 disability claim.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during my claim under this plan, 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 the 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 of Canada from www.wawanesalife.com or from our Customer Service Department, Wawanesa Life, 236 Carlton Street, Winnipeg, Manitoba, 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 Street, Winnipeg, Manitoba, 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 the 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 disability claim.

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

Policy Number: _____

Plan Member Name (print): _____

Plan Member Signature

Date Signed (mm/dd/yyyy)