



A. INFORMATION SUPPLIED BY PLAN SPONSOR

Date Employed _____ (YY/MM/DD)	Plan Sponsor Name _____ <i>Employee must receive a T4 from this Policyholder.</i>	Policy # _____	Class # _____
Coverage Effective Date _____ (YY/MM/DD)	Plan Member Occupation _____	Number of Hours worked per week _____	Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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 _____ (YY/MM/DD)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Do you have a spouse*? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you have dependent child(ren)? (Under 21 years of age) Ages 21-25 attending school full time* <i>*Submit a completed Dependent Child Eligibility form for each child</i> <input type="checkbox"/> Yes <input type="checkbox"/> 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:

<input type="checkbox"/> I require Single coverage. I have no dependents. <input type="checkbox"/> I require Single coverage. My dependents are covered under another plan. Carrier Name _____ Plan# _____	<input type="checkbox"/> I require Family coverage. Coverage for myself and dependents. <input type="checkbox"/> I wish to co-ordinate my coverage with my spouse's plan. Carrier Name _____ Plan# _____
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	Last Name	First Name	Initial	Sex	Birth Date YY/MM/DD
Spouse					
1 st Child					
2 nd Child					
3 rd Child					
4 th Child					
5 th Child					



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

D. BENEFICIARY DESIGNATION

Beneficiary's Name(s) <input type="checkbox"/> New <input type="checkbox"/> 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 400-200 Main Street, Winnipeg, MB R3C 1A8 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, 400-200 Main Street, Winnipeg, MB R3C 1A8.

- 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 _____