



**Group Benefits  
Enrollment -Application**

Please Indicate:

New Plan Member

Reinstatement

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

**A. INFORMATION SUPPLIED BY PLAN SPONSOR**

Date of Hire <small>(YY/MM/DD)</small>	Plan Sponsor Name	Account Name & Number	Class
Coverage Effective Date <small>(YY/MM/DD)</small>	Plan Member Occupation	Number of Hours worked per week	Earnings \$ _____ Hourly Monthly Weekly 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 <small>(YY/MM/DD)</small>	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					
1 <sup>st</sup> Child					
2 <sup>nd</sup> Child					
3 <sup>rd</sup> Child					
4 <sup>th</sup> 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:

<b>Health</b>	Single	Family	None
<b>Vision</b>	Single	Family	None
<b>Dental</b>	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.

<b>I waive Extended Health for:</b> Myself and my dependents My dependents ONLY	<b>I waive Vision for:</b> Myself and my dependents My dependents ONLY	<b>I waive Dental for:</b> Myself and my dependents My dependents ONLY
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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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<b>Total</b>			<b>100%</b>	

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 400-200 Main Street, Winnipeg, MB R3C 1A8 or at [www.wawanesalife.com](http://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.*

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)