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Group Operation
P.O. BOX 1640, Windsor, ON N9A 0C8
1-800-665-7076

Alternate Coverage Information

EMPLOYER/EMPLOYEE IDENTIFICATION

Policy #: _____ Plan Sponsor Name: _____ Claimant ID#: WLI

Plan Member Name: _____ (Last Name) _____ (First Name)

This form must be completed in conjunction with the Notice of Change form to ensure full details of dependents are provided.

- ☐ Alternate coverage has now terminated. Coverage under Wawanesa Plan for Health, Vision and/or Dental Benefits was previously waived.
- ☐ Alternate coverage is still in effect. Application is being made to Wawanesa Life to provide additional coverage.

Coverage required for: Health ☐ Vision ☐ Dental ☐

The following information is required to apply for coverage at this time:

1. The reason the Plan Member and/or his dependents are no longer covered under an alternate policy.

2. The date that the alternate coverage terminated. _____

3. The name and address of the Plan Sponsor where alternate coverage was provided (if covered through a plan at work).

4. The insurance company name and the policy number of the terminated or alternate plan(s).

5. Benefits that the Plan Member and/or his spouse had through the terminated plan:
   - ☐ Health
   - ☐ Vision
   - ☐ Dental
   - ☐ Other (List): _____

_____ Signature of Plan Member

_____ Date

For Wawanesa Life Executive Office Use Only

Alternate Coverage Terminated/COB Updated Date: _____