



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

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 Dental
 - Vision Other (List): _____
 - _____
 - _____
 - _____

 Signature of Plan Member

 Date

For Wawanesa Life Executive Office Use Only
 Alternate Coverage Terminated/COB Updated Date: _____