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

Clear Print

Basic & Enhanced **Health Statement**

INSTRUCTIONS

1. Complete all sections below, sign and date this form.
2. Remove and retain for your records the "Notice of Medical Information Bureau".
3. Should further information be required, Wawanesa Life will contact you directly.
4. If approved for "With Evidence Long Term Disability Coverage", additional monthly premium will apply.

Reason for completing this form?

☐ Employee "With Evidence Long Term Disability Coverage" Application

☐ Employee Late Application* ☐ Spouse Late Application* ☐ Dependent Late Application*

*All Late Applicants will be subject to Dental restrictions for the first twelve months of coverage.

APPLICANT INFORMATION

Please Type or Print Clearly

Group Number: _____ Certificate Number: **WLI**

Employee Name _____ (Last Name) _____ (First Name) _____ (Initial)

Applicant Name (If Different) _____ (Last Name) _____ (First Name) _____ (Initial)

Mailing Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

QUESTIONNAIRE

1.	Within the last two years have you had a stroke, heart attack or been advised to have heart surgery?	☐ Yes ☐ No
2.	Within the last three years have you had any indication of, consulted a physician for, or received treatment for cancer?	☐ Yes ☐ No
3.	Within the last three years have you been declined for individual insurance by any insurer?	☐ Yes ☐ No
4.	Have you been diagnosed, treated for, or had any indication of AIDS or AIDS related complex?	☐ Yes ☐ No
5.	Are you currently restricted to a wheel chair, bedridden, hospitalized or confined to a nursing facility?	☐ Yes ☐ No

If you answered "No" to all of the above questions, coverage is automatically approved. Sign, date and submit to Wawanesa Life within 21 days of signing. If you answered "Yes" to any of the above questions, coverage is not available. If approved, coverage will be effective on the first of the following month.

AUTHORIZATION AND ACKNOWLEDGEMENT

I have read the above questions and the answers provided are complete and true to the best of my knowledge. I hereby agree that they form part of the Application for Insurance.

Date _____ Signature _____

This notice must be detached and retained by the Applicant

NOTICE OF MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Wawanesa Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's files, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

Wawanesa Life, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

In the processing of the application for insurance, the Wawanesa Life Insurance Company may obtain Motor Vehicle Driving abstract/records, a personal investigation or consumer reports containing personal information about the applicant.