



Please return this completed form and supporting documents to:

Group Benefit Services
400-200 Main Street, Winnipeg, MB R3C 1A8
For inquiries, please call 1-800-665-7076

DEATH BENEFIT PLAN SPONSOR STATEMENT CLAIMANT STATEMENT

<p>PLAN SPONSOR STATEMENT <i>To be completed by the Plan Sponsor</i></p>	<p>Plan Sponsor _____ Group Plan # _____ Plan Member _____ Plan Member ID <u>WLI</u> <small>Last Name</small> <small>First Name</small></p> <p>Type and Amount of Claim</p> <p><input type="checkbox"/> Life, Plan Member \$ _____ <input type="checkbox"/> Life, Dependent Spouse \$ _____ <input type="checkbox"/> Life, Dependant Child \$ _____ <input type="checkbox"/> Accidental Death, Plan Member \$ _____ <input type="checkbox"/> Optional Life, Plan Member \$ _____ <input type="checkbox"/> Optional Life, Dependent Spouse \$ _____ <input type="checkbox"/> Optional Life, Dependant Child \$ _____</p> <p>If deceased is Plan Member, please provide:</p> <p>Date of hire: _____ Effective Date of Coverage: _____ Occupation: _____ Salary/wages at last date worked \$ _____ Date last worked: _____ Reason for leaving: _____</p> <p>I certify that to the best of my knowledge, the above statements are true and correct.</p> <p>_____ Date _____ Signature and Title _____</p>
<p>CLAIMANT STATEMENT Deceased Information <i>To be completed by the Claimant</i></p>	<p>Deceased's Name: _____ Relationship to Plan Member: _____ <small>Last Name</small> <small>First Name</small></p> <p>Address: _____ <small>City/Town</small> <small>Province</small> <small>Postal Code</small></p> <p>Date of Birth: _____ Date of Death: _____ Cause of Death: _____</p>
<p>CLAIMANT INFORMATION <i>To be completed and signed by Claimant of benefit</i></p>	<p>Claimant's Name: _____ Relationship to Deceased: _____ <small>Last Name</small> <small>First Name</small></p> <p>Address: _____ <small>City/Town</small> <small>Province</small> <small>Postal Code</small></p> <p>Telephone Number: _____ Email Address: _____ Date of Birth: _____</p> <p>In what capacity or on what basis do you claim the benefit? (<i>check one</i>)</p> <p><input type="checkbox"/> Named Beneficiary <input type="checkbox"/> Named Beneficiary; Guardian <input type="checkbox"/> Estate Executor <input type="checkbox"/> Trustee: <input type="checkbox"/> Other, specify: _____</p> <p>Do you wish the benefit to be:</p> <p><input type="checkbox"/> Lump Sum payment <input type="checkbox"/> Paid in installments <input type="checkbox"/> Placed on deposit</p> <p>I authorize the use of my social insurance number for income tax reporting purposes when required in payment of the benefit's interest.</p> <p>_____ Social Insurance Number _____ Signature _____</p>



Authorizations and Declarations

AUTHORIZATIONS

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that the deceased has attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering the death benefit.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during this claim under this plan, with the insurer's reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of the deceased, or which may be opened in the future by my insurer, for the use in accordance with the object of such other files.

I understand that by furnishing this form and investigating the claim or by accepting Proofs of Claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the plan.

CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

I consent to Wawanesa Life collecting, using and disclosing my personal information and that of the deceased 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 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 and that of the deceased. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information and that of the deceased may be shared as required by the laws of those jurisdictions. 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 www.wawanesalife.com or from our Customer Service Department, Wawanesa Life, 400-200 Main Street, Winnipeg, MB R3C 1A8.

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, Manitoba R3C 1A8.

DECLARATION AND SIGNATURE

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting the deceased for the purpose of administering the death benefit.

A photocopy or an electronic reproduction of this document will be as valid as the original.

Claimant's Name (Print)

Date (yy/mm/dd)

Claimant's Signature

Date (yy/mm/dd)

Witness Signature