SHORT-TERM DISABILITY CHECKLIST AND DIRECT DEPOSIT AUTHORIZATION

Please return this completed form and supporting documents to:

Wawanesa Life - Claims
400-200 Main Street, Winnipeg, MB R3C 1A8
For inquiries, please call: 1-844-318-0411, #4
Fax 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

Claim Checklist

To ensure the assessment of your Group Short-Term Disability benefit is completed as quickly as possible, please review the following items, and verify they have all been included.

- ☐ Short-Term Disability Plan Sponsor Statement form – completed and signed by Plan Sponsor
- ☐ Short-Term Disability Plan Member Statement form – completed and signed by you
- ☐ Short-Term Disability Attending Physician Statement form – completed and signed by your physician
- ☐ Medical Chart notes
- ☐ Authorizations and Declarations Form – signed by you. (Attached to Plan Member Statement)
- ☐ Direct Deposit Authorization signed and completed by you (include a copy of void cheque)

Direct Deposit Authorization

Direct Deposit is the method of payment by Wawanesa Life. If you have not already signed up, please complete this section.

☐ Initial Request ☐ Modification Group Plan #_____ Plan Member ID _____

Plan Member _____ _____ Telephone Number _____
Last Name First Name

Financial institution name_____

Financial institution address_____

Type of account: ☐ Chequing ☐ Savings

Branch number_____ Account number_____ Institution number_____

Please attach a personalized void cheque with this form.

I hereby authorize The Wawanesa Life Insurance Company ("Wawanesa Life" to deposit my benefit payment to the account and the financial institution specified above. This authority is to remain in full force and effect until Wawanesa Life has received written notification form me of its termination in such time and in such manner as to afford a reasonable opportunity to act on it.

Should Wawanesa Life inadvertently deposit into my account any monies not rightfully belonging to me, I authorize Wawanesa Life to debit my account for such amount.

_____ _____ _____ _____
Signature Date (yy/mm/dd) Account holder signature (if applicable) Date (yy/mm/dd)

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force.
Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

For Wawanesa Life use only Received

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