Print Clear

Short-Term Disability Benefits

Plan Member Statement

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

Plan Member Information

Plan Member _____ Date of Birth _____
Last Name First Name Initial (yy/mm/dd)

Address _____
Street City Province Postal Code

Phone Number _____
Home Cell Work

Email _____ Social Insurance Number _____

Plan Member Disability Information

Please describe your current condition and how it prevents you from working

_____

_____

_____

What where your first symptoms?

_____

_____

When did you first notice symptoms? _____

Where did the accident/injury occur? _____
Location Date (yy/mm/dd) Time

Was there another party at fault? ☐ Yes ☐ No

Was alcohol involved? ☐ Yes ☐ No

Was it reported to the police? ☐ Yes ☐ No
If 'Yes', please provide a copy of the incident/police report.

Were any charges laid? ☐ Yes ☐ No

Are there any other factors that prevent you from working? _____

_____

_____

Is your condition related to your occupation? If 'Yes', please explain: _____

_____

_____

Plan Member Treatment Information

Were you admitted to a hospital? ☐ Yes ☐ No

Name of Hospital _____ Admission Date _____ (yy/mm/dd) Discharge Date _____ (yy/mm/dd)

List all health care providers you have consulted (eg. Chiropractor, doctor, etc.)

Name	First Consultation (yy/mm/dd)	Last Consultation (yy/mm/dd	Reason

List your treatment including medications

Name of Treatment	When treatment started (yy/mm/dd)	Reason for treatment	Any change in treatment (i.e., dosage, type of therapy, etc.)	Date of change (yy/mm/dd)

Plan Member Current Employment Information

Last day you worked before disability _____ (yy/mm/dd) Hours Worked _____ ☐ Fill-Time ☐ Part-Time

Date you were first unable to work _____ (yy/mm/dd)

Have you returned to work ? ☐ Yes ☐ No If 'Yes', when _____ (yy/mm/dd)

If you have not returned to work, when do you expect to? _____ (yy/mm/dd)

Have you performed any other work since that date ? If 'Yes', please describe _____

Are you able to do any other work ? If 'Yes', please dsecribe _____

Plan Member Financial *please provide copies of any initial benefit statements*

Have you applied for or are receiving the following:

	Applied Yes	Applied No	Awarded Yes	Awarded No	Date Applied/ Date Awarded	Amount
Canada Pension Plan/Quebec Pension Plan	☐	☐	☐	☐		
Worker's Compensation Board Benefits (or similar)	☐	☐	☐	☐		
Employee Insurance Benefits	☐	☐	☐	☐		
Automobile Insurance Benefits	☐	☐	☐	☐		
Any other Disability Benefits	☐	☐	☐	☐		
Employer Sponsored Retirement/Pension Plan Income	☐	☐	☐	☐		
Self-Employment Income or other Employment Income	☐	☐	☐	☐		
Old Age Security	☐	☐	☐	☐		
Other_____	☐	☐	☐	☐		

For the duration of your claim for benefits, it is your responsibility to notify Wawanesa Life of:

- Any work performed, whether or not you have received a wage or renumeration
- Any employment income paid to you or any other person or party as a result of work performed by you

Authorizations

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my 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 my disability claim.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during my 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 me, or which may be opened in the future by my insurer, for 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 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. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information 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 Wawanesa Life 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 me 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 me for the purpose of administering my disability claim.

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

Group Plan #	Plan Member Name (Print)
Date (yy/mm/dd)	Plan Member Signature