PRINT RESET

Wawanesa Life®

WAVIER OF PREMIUM
PLAN MEMBER STATEMENT

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

PLAN MEMBER INFORMATION

Plan Sponsor_____ Group Plan#_____

Plan Member_____ ☐ Male ☐ Female Date of Birth_____
Last Name First Name Initial (yy/mm/dd)

Address:_____
City/Town Province Postal Code

Telephone Number:_____ Email Address:_____

FAMILY INFORMATION

Spouse's name_____ Date of Birth_____
Last Name First Name (yy/mm/dd)

Is your spouse employed? ☐ Yes ☐ No

Dependent Children:	Date of Birth:	At Home	In School
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No

DISABILITY INFORMATION

Please provide a copy of the incident / police report

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

What were your first symptoms?_____

When did you first notice symptoms?_____

If accident, describe the injury, how it occurred and how it prevents you from working.

Where did the accident/injury occur?_____

Time & date of accident_____
(yy/mm/dd)

Was another party at fault? ☐ Yes ☐ No Was alcohol involved? ☐ Yes ☐ No

Was it reported to the police? ☐ Yes ☐ No Were any charges laid? ☐ Yes ☐ No

Are there any other factors that prevent you from working?

Is your condition related to your occupation? Please explain:

Has a claim been filed with another wage loss provider? ☐ Yes ☐ No

If 'Yes', select provider ☐ WCB/WSIB/CSST ☐ CPP/QPP ☐ Auto ☐ Other, specify_____

Date Filed_____ Decision_____ Amount_____
(yy/mm/dd)

TREATMENT INFORMATION

Date first treated_____
(yy/mm/dd)

Were you hospitalized? ☐ Yes ☐ No If 'Yes', where_____

Admission Date_____ Discharge Date_____
(yy/mm/dd) (yy/mm/dd)

List all heath care providers you have consulted during the past two years (*eg. chiropractor, doctor*)

Name	First Consultation	Last Consultation	Reason

Since your absence from work, what type of treatment have you received? (*eg. Medical, physiotherapy, counselling, etc.*)

CURRENT EMPLOYMENT INFORMATION

Last day you worked before disability_____ Hours Worked_____
(yy/mm/dd)

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? ☐ Yes ☐ No
If 'Yes', describe.

Are you able to do any other work? ☐ Yes ☐ No
If 'Yes', describe.

Authorizations and Declarations

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.

WLI# _____
Plan Member ID#

_____
Plan Member's Name (Print)

_____
Date (yy/mm/dd)

_____
Plan Member's Signature