WAIVER OF PREMIUM
PLAN SPONSOR 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
Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

PLAN SPONSOR IDENTIFICATION

Group Plan # ____________________ Account # ____________

Plan Sponsor ____________________________

Address: ____
City/Town Province Postal Code

Telephone Number: ____________________ Email Address: ____________________

Fax: ____________________

PLAN MEMBER IDENTIFICATION

Plan Member ______________________________ Plan Member ID ____________
Last Name First Name Initial

EARNINGS INFORMATION

*If **WCB/WSIB/CSST** claim, attach initial report of illness or injury and award notice*

Plan Member's salary as of last day worked ________ ☐ Hourly ☐ Monthly ☐ Annually

Effective date of salary ________ (yy/mm/dd)

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

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

EMPLOYMENT INFORMATION

Effective date of insurance ________ (yy/mm/dd) Date of hire ________ (yy/mm/dd)

Last day worked ________ (yy/mm/dd) Hours worked ________

Salary or sick leave benefits paid to: ________ (yy/mm/dd) If laid off or on leave, date of commencement and recall

Commencement date ________ (yy/mm/dd) Recall date ________ (yy/mm/dd)

Employee Classification: ☐ Full Time: Hours per week ______ ☐ Part Time: Hours per week ______

Please explain the Plan Member's typical work week (*eg. Monday to Friday, 8 am to 5 pm*)

Reason for absence: ☐ Medical ☐ Leave of absence ☐ Dismissed ☐ Temporary lay-off
☐ Quit ☐ Work related accident or sickness ☐ Strike ☐ Retired
☐ Other ____

Has the Plan Member returned to work? ☐ Yes ☐ No

If 'Yes', please indicate date ________ (yy/mm/dd) If 'No', is return to work date know ________ (yy/mm/dd)

JOB INFORMATION

Plan Member's position/title ____

Effective date of position/title ________ (yy/mm/dd)

What department does the Plan Member work in? ______________________________

JOB INFORMATION

Continued

For questions A, B, and C, Frequency is defined as follows:
Occasionally: 1-20%
Frequently: 21-50%
Always: 51+%
N/A: Not Applicable

What are the essential duties of this job and what percentage of time do they involve?

Duties	Percentage (%)

A. Work environment - Does the job involve:

	Frequency O	F	A	N/A
Outside	☐	☐	☐	☐
Extreme cold or heat	☐	☐	☐	☐
Toxic fumes	☐	☐	☐	☐
Damp or humid environment	☐	☐	☐	☐
Above or below ground	☐	☐	☐	☐
Handling chemicals	☐	☐	☐	☐

B. Mobility - Does the job involve:

	O	F	A	N/A
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐
Reaching				
Above shoulder height	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐

C. Strength - Does the job require the Plan Member to carry more than:

	O	F	A	N/A
50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 kg	☐	☐	☐	☐

Does the job require the Plan Member to lift more than:

	O	F	A	N/A
50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 kg	☐	☐	☐	☐

Indicate any equipment used by the Plan Member (eg. computer, drill, etc.)

Type	Percentage (%) of day

Were any modifications made to the Plan Member's job duties as a result of the condition? ☐ Yes ☐ No
If 'Yes', please explain and give the effective date.

COMMENTS

Please provide any additional information that you believe should be considered in assessing this claim.

I certify that to the best of my knowledge, the above statements are true and correct.

Name ____________ Title ____________ (yy/mm/dd) ____________ Authorized Signature ____________

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.

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