PRINT RESET

Wawanesa Life®

WAVIER OF PREMIUM
PLAN SPONSOR 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 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_____ Date of hire_____
(yy/mm/dd) (yy/mm/dd)

Last day worked_____ Hours worked_____
(yy/mm/dd)

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

Commencement date_____ Recall date_____
(yy/mm/dd) (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_____ If 'No', is return to work date know_____
(yy/mm/dd) (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:
***O**ccasionally: 1-20%*
***F**requently: 21-50%*
***A**lways: 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	Frequency	O	F	A	N/A
Outside	☐	☐	☐	☐	Damp or humid environment	☐	☐	☐	☐
Extreme cold or heat	☐	☐	☐	☐	Above or below ground	☐	☐	☐	☐
Toxic fumes	☐	☐	☐	☐	Handling chemicals	☐	☐	☐	☐

B. Mobility - Does the job involve:

Standing	☐	☐	☐	☐	Reaching				
Walking	☐	☐	☐	☐	Above shoulder height	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	At shoulder height	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	Below shoulder height	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	Bending or crouching	☐	☐	☐	☐

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

					Does the job require the Plan Member to lift more than:				
50 lbs / 22.7 kg	☐	☐	☐	☐	50 lbs / 22.7 kg	☐	☐	☐	☐
20 lbs / 9.1 kg	☐	☐	☐	☐	20 lbs / 9.1 kg	☐	☐	☐	☐
10 lbs / 4.5 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 _____