QUICK APPLICATION FOR REINSTATEMENT
for life insurance policies that have lapsed within the past 6 months

INSTRUCTIONS

- **Use this form to reinstate a life insurance policy that lapsed within 180 days from the first overdue premium.**
- **Use Application for Reinstatement and/or Change to reinstate a life policy that lapsed more than six months ago.**
- **To reinstate a Quick Issue CI policy, an Instant Issue policy or a Final Expense policy, complete an application for that plan and provide the current policy number.**

We may require further evidence of insurability to reinstate your policy.

A. POLICY IDENTIFICATION (please print) — POLICY NO. ______

☐ Life Insured ☐ Policy Owner	☐ Policy Owner ☐ Second Life Insured
Name	Name
Address	Address
Telephone Res.: Bus.:	Telephone Res.: Bus.:

B. EVIDENCE OF INSURABILITY

QUESTIONS 1-5 ARE TO BE ANSWERED BY **EACH** INDIVIDUAL TO BE COVERED. **PROVIDE DETAILS TO ALL 'YES' ANSWERS IN DETAILS SECTION BELOW.**	Life Insured YES	Life Insured NO	Second Insured YES	Second Insured NO
1. Within the past year, have you been admitted or been advised to be admitted to a hospital or medical facility, or had surgery performed or recommended?	☐	☐	☐	☐
2. Within the past year, have you been treated for heart disease, diabetes, stroke or cancer, or has treatment for these conditions been recommended by a health care professional?	☐	☐	☐	☐
3. Within the past year, have you been absent from work for more than 10 consecutive days for any accident or sickness?	☐	☐	☐	☐
4. Have you ever been diagnosed with any immune deficiency disorder, including AIDS, AIDS Related Complex (ARC) or any generalized enlargement of the lymph glands or have you had any test results that indicate possible exposure to the AIDS (i.e. HIV, HTLV-III, LAV) virus?	☐	☐	☐	☐
5. Have you ever been declined for life, disability, critical illness or long-term care insurance, or been offered restricted coverage or coverage at a non-standard rate?	☐	☐	☐	☐

DETAILS – If you answered "Yes" to any of the questions in section B, list the question number and provide full details.

QUESTION NUMBER	LIFE INSURED	DETAILS AS TO DIAGNOSIS, DURATION, RESULTS	DATE	NAME AND ADDRESS OF PHYSICIAN AND/OR HOSPITAL

C. PAYMENT INFORMATION

Payment options: ☐ Pre-Authorized Debit (complete PAD section below): ☐ Monthly ☐ Semi-Annual ☐ Annual

or ☐ Billing: n/a ☐ Semi-Annual ☐ Annual

Total Modal Premium ______ Amount paid with this application ______

Pre-Authorized Debit (PAD)

Account Owner Name(s) ______ Telephone ______

Account Owner Address (if different from policyowner) ______

☐ Use my current Wawanesa Life PAD under Policy # ______ or PAD # ______ or:

☐ Establish a new PAD and use: ☐ Details from initial premium cheque ☐ Details from VOID cheque (attached) ☐ Information provided below:

Transit # ______ Fin. Inst. # ______ Account # ______

Branch Address ______ Withdrawal date: ☐ Policy date or ☐ ____ (1st – 28th)

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Wawanesa Life

D. AGREEMENT AND DECLARATION / AUTHORIZATION AND SIGNATURES

Each of the undersigned insureds and/or policy owners agree that:

1. All statements, agreements, representations and answers made in this Application, and any additional declarations or answers which may be made in any personal declaration required in connection with this Application, together with all prior applications, shall be consideration for the basis of the reinstatement and/or changed policy(ies) hereby requested.
2. The answers to the statements and questions are complete, true and correctly recorded.
3. In order to effect the change the Company shall have the right either (a) to cancel the present policy and make another policy containing current terms corresponding to the terms of the changed policy, or (b) to amend the present policy.
4. Except as changed by this Application, any indebtedness under the policy and the rights of any beneficiary, assignee or other person having an interest in the policy shall remain as unchanged.
5. Delivery to and acceptance by the policy owner of any policy issued in consequence of this Application will ratify any amendments to the change of policy made by the Company.
6. The reinstatement and/or change shall not take effect until: (a) approved by the authorized officers of the Company, (b) all premiums and fees required have been paid, and (c) the policy is delivered, no change having taken place in the insurability of the Life Insured, Second Life Insured or Insured Children subsequent to the completion of this Application.
7. If, within two years from the date of approval of the reinstatement and/or change, the Life Insured or any other individuals proposed for coverage dies by suicide, whether sane or insane, or if any information submitted in support of this Application is proved to be materially incomplete or untrue, the reinstatement and/or change will be void.

AUTHORIZATION: THE FOLLOWING AUTHORIZATION IS VALID FOR EACH INDIVIDUAL FOR WHOM EVIDENCE OF INSURABILITY IS REQUIRED.

I acknowledge having received the notices regarding Medical Information Bureau and Investigative Reports, and consent to such reports being obtained by Wawanesa Life.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, The Medical Information Bureau, Motor Vehicle Department concerning driver abstract, or other organization, institution or person that has any records or knowledge of me or my health or of my children or their health to give Wawanesa Life or its reinsurer(s) any such information.

I authorize Wawanesa Life to perform such tests, examinations, x-rays, electrocardiograms, urinalysis, general blood profiles including blood tests for AIDS as may be required to medically underwrite this Application for insurance. I authorize the Medical Director of Wawanesa Life to release all medically related information obtained during the underwriting process to my/our personal physician or other medical practitioner.

PRE-AUTHORIZED DEBIT (PAD) AUTHORIZATION (if applicable – please complete PAD section on page 1)

I request and authorize Wawanesa Life to make withdrawals from the account designated on page 1 of this application or from any subsequently designated account in order to make policy payments and/or specific payments on loan indebtedness, under the following terms:

1. Withdrawals will be made according to the payment frequency indicated on the application on the policy issue date unless a particular withdrawal day is specified.
2. If a monthly PAD is returned as insufficient funds, the next PAD amount will be for the two months of premium. Notification will be provided prior to this double withdrawal.
3. I may revoke my authorization at any time, subject to providing written notice of 10 days to Wawanesa Life. *(For more information on your right to cancel a PAD agreement, contact your financial institution or visit www.cdnpay.ca.)*
4. I have certain recourse rights, provided under the personal PAD agreement, if any debit does not comply with the agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with the personal PAD agreement. *(For more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.)*
5. I may provide written request to add/delete policies to the PAD agreement or change bank information without completing a new PAD agreement.
6. **I waive the right to receive 10 days' notice of an increase or decrease in the amount of the automatic withdrawal due to premium changes during the underwriting process. Notification of premium changes will be provided when the policy is issued.**

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; receiving payments of insurance premiums and policy loan repayments; withdrawing premiums from and depositing funds into my account (applicable if PAD Agreement is signed); 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 have read and understood that Wawanesa Life may share my personal information with the required people, organizations and service providers as described in the Notice of Consent & Disclosure Regarding Personal Information on Customer Copy, who may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions.

I recognize that in providing services to me in the future and providing me with the benefits included in the policy I am applying for, Wawanesa Life may need to collect, use and disclose additional personal information about me. I confirm that this consent applies to that personal information as well.

I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to provide me with the product or service being applied for or having to terminate the policy.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from the Wawanesa Life Head Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

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.

I confirm that I have read, understood and accepted the terms and conditions of the agreements, declarations and authorizations contained in this application. A photocopy or an electronic reproduction of this document will be as valid as the original.

Signed at __________________________ in the province of ____. Date ____________________________________

Life Insured, or parent if Life Insured is under age 16 (please print)	Life Insured, or parent if Life Insured is under age 16 (signature)	Child under Child Protection Rider, if age 16 or older (signature)
Second Life Insured (please print)	Second Life Insured (signature)	Witness/Advisor/Broker (signature)
Policy Owner, if other than Life Insured (please print)	Policy Owner, if other than Life Insured (signature)	PAD Account Owner (signature)

BROKER'S DECLARATION (if applicable)

I declare that I have asked and fully recorded the answers of all lives proposed to all questions on this Application, and that I know of nothing that is material to their insurability that has not been recorded herein. I am aware of and in compliance with the Company's Sales Code of Ethics.

BROKER (please print)	BROKER (signature)

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NOTICES & DISCLOSURE STATEMENTS
CUSTOMER COPIES

NOTICE OF MEDICAL INFORMATION BUREAU, INC. (MIB)

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however, make a brief report thereon to the MIB, a non-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, ON M5G 1R7, telephone number (416) 597-0590.

We, or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INVESTIGATIVE REPORTS

In the processing of the application for reinstatement, The Wawanesa Life Insurance Company may obtain Motor Vehicle Driving abstract/records, a personal investigation or consumer reports containing personal information about the individuals proposed for insurance.

NOTICE OF CONSENT TO RELEASE MEDICAL/UNDERWRITING INFORMATION

As part of the underwriting process, the Medical Director of Wawanesa may need to release medically related information obtained during the underwriting process to your personal physician or other medical practitioner. We may also need to disclose information regarding the underwriting factors to your Wawanesa Life advisor/broker.

NOTICE OF CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

We collect, use and disclose your personal information in order to administer the products and services you have requested. Personal Information is collected for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; receiving payments of insurance premiums and policy loan repayments; withdrawing premiums from and depositing funds into your account (applicable if PAD Agreement is signed); detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law.

We may share your personal information with the following people, organizations and service providers: Wawanesa Life employees and brokers who require this information to perform their jobs; third party providers who require this information to provide their services to you, which may include paramedical agencies, underwriters, claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies to allow them to evaluate and administer any insurance risk that the accept; the Medical Information Bureau as explained the notice provided; people to whom you have granted access; and people who are legally authorized to view your personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. Your information may be shared as required by the laws of those jurisdictions.

There are other situations where we may share aspects of your personal information with others, as described below:

- We may share medical information collected about you with your doctor.
- We may share your personal information with an organization or person from whom we are collecting information about you, but only as required to obtain the information needed.
- If laboratory tests performed on our behalf show that you have tested positive for infectious diseases such as HIV or hepatitis, we may report this information to the appropriate public health authorities, as required.

Because the medical information you include in this application becomes part of the printed contract, in the case of a corporate or joint policy, your medical information may be included in the policy contract issued to the policy owner(s) and any subsequent owners.

In order to provide services to you in the future and provide you with the benefits included in the policy, Wawanesa Life may need to collect, use and disclose additional personal information about you. We may not require you to provide consent at that time.

Any restriction or withdrawal of your consent may result in Wawanesa Life being unable to provide you with the product or service being applied for or having to terminate the policy.

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