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CLAIMANT'S STATEMENT – WAIVER OF PREMIUM BENEFIT

POLICY NUMBER(S) _____

CLAIMANT INFORMATION

NAME _____ DATE OF BIRTH ____ ____ ____ (DAY MONTH YEAR)

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE ____ ____

PHONE NUMBERS: HOME ___ - ___ - ____ BUSINESS ___ - ___ - ____

NAME OF EMPLOYER _____

HISTORY OF PRESENT DISABILITY DUE TO ☐ INJURY ☐ SICKNESS

1. Date injury occurred or sickness commenced: D ____ M ____ Y ____

2. If injury, how and when did it occur?

3. Describe injuries or nature of sickness:

4. Were you confined to hospital ☐ YES ☐ NO If YES, please complete the following:

Name of Hospital	Address	Date of Admission	Date of Discharge

5. List all doctors you have consulted because of your present disability or any other reason during the past two years:

Name of Doctor	Address	Reason	Date First Consulted	Date Last Consulted

6. What was your occupation immediately prior to becoming disabled?

7. Give specific details of your job responsibilities:

8. What is the last date on which you were able to do this work? D ____ M ____ Y ____

9. How has your condition affected your ability to do this work?

10. Have you done any work whatsoever since the date total disability commenced? ☐ YES ☐ NO If YES, please give details:

11. Give the expected date of return to work: D ____ M ____ Y ____

12. Please outline below **any** income you are currently receiving or have applied for, such as Worker's Compensation, Group/Individual Disability Benefits, salary/wage continuance/pension through employer, Government Disability or Pension. Please attach copies of any correspondence related to the above, award notice or cheque stub.

Source of Income	Date Applied	Date Income Commenced	Amount of Payments	Frequency of Payments

13. If you are **not** currently receiving any disability benefits or income, please indicate below if any and when you will be applying. If you are not planning to apply, please provide the reasons for not applying.

14. Do you have any other policies with The Wawanesa Life Insurance Company? ☐ YES ☐ NO If YES, indicate policy numbers:

15. Additional information and remarks:

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 claim.

I also authorize my insurer, or its reinsurers, to exchange the personal information obtained during my application for this policy, or any claim under this policy, with the insurer's Agents, affiliates, 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 further authorize any employer, union, insurance company, prepayment organization or any government agency to give The Wawanesa Life Insurance Company any additional information required in connection with this claim.

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 policy.

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 and agents who require this information to perform their jobs; claim 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 the Wawanesa Life Executive 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.

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 the Company 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.

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

_____ _____

DATE SIGNATURE OF CLAIMANT

PLEASE RETURN FORM TO: The Wawanesa Life Insurance Company, 400 - 200 Main Street, Winnipeg, MB R3C 1A8, FAX 1-888-985-3872

LIMITATION PERIOD NOTICE

Every action or proceeding against the Company for a recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.