Wawanesa Life

Group Division
702 – 191 Broadway, Winnipeg, MB R3C 3P1

Group Benefits
Enrollment – Compulsory Application

Please Indicate: New Employee ☐ Reinstatement ☐

A. EMPLOYEE INFORMATION	Please Type or Print Clearly		**Policy No.**	
Surname	First Name	Initial	**Date of Birth** Year / Month / Day	**Sex** ☐ Male ☐ Female
Home Address ~~c/o #6, 1680 Gilmore Ave.~~			**Marital Status** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Common-Law ☐ Separated	
City ~~Burnaby~~	Province BC	Postal Code ~~V5C 4T3~~		

B. DEPENDENT INFORMATION

List all eligible dependents below: (If coverage is not required, please complete Part C. Refusal of Benefits)

					Birth Date			*Other Insurance	
	Surname	**First Name**	**Initial**	**Sex**	**Year**	**Month**	**Day**	**Health**	**Dental**
Spouse									
1st Child									
2nd Child									
3rd Child									
4th Child									
5th Child									

***Other Insurance: Co-ordination of Benefits**

If your family members have insurance coverage under any other plan providing similar benefits, your benefits will be coordinated with the other plan(s). Claims will be coordinated according to industry guidelines so that the total payments under all plans do not exceed 100% of the total eligible expenses.

You must declare other coverage by completing the Other Insurance columns for dependents covered under another plan.

If your spouse has other coverage, place an S (Wawanesa plan is considered the Secondary plan) in the Other Insurance column.

For dependent children eligible under your spouse's plan, place an S if your birthdate falls later in the year than the birthdate of your spouse. (e.g. If your birthdate is in June and your spouse's birthdate is in March – place an S in the Other Insurance Column)

In situations of divorce or separation, if you have custody of a dependent child, the Wawanesa plan will be considered the Primary (first) plan. If you do not have custody, and other insurance coverage exists for this child, place an S in the Other Insurance column. (The plan of the parent with custody of the child will be the Primary plan).

C. REFUSAL OF BENEFITS

I have been offered the opportunity to join the firm's Group Insurance Plan and the benefits provided by this Plan have been explained to me. However, I **decline** to participate in the following benefits:

I decline Extended Health for: ☐ Myself and my dependents ☐ My dependents ONLY

I decline Dental for: ☐ Myself and my dependents ☐ My dependents ONLY

Note: Coverage can only be refused for the above benefits if you and/or dependents are covered by similar group benefits through your spouse's employer.
Spousal Insurer's Name: _____ Plan Number: _____

If you lose spousal coverage, you **must** apply for coverage under this Plan within 31 days of loss of such coverage.
If you apply for coverage after the 31 days, you may be required to provide evidence of insurability and your dental benefits will be restricted.

D. INFORMATION SUPPLIED BY POLICYHOLDER

Date Employed Year / Month / Day	Name of Group Policyholder		Division Name & Number	Class
	Precision Restoration Inc		Regular Employee	
Effective Date Year / Month / Day	Occupation of Employee	Number of Hours Worked per week	Earnings	
		40	$ ☐Hourly ☐Weekly ☐Monthly ☐Annually	

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Policy No. _____ **Employee Name:** _____
Surname **First Name**

E. BENEFICIARY DESIGNATION (the employee reserves the right to change the beneficiary)

Beneficiary's Name(s)	% Allocated	Relationship of Beneficiary to Applicant
_____ Surname First Name Initial	_____	_____
_____ Surname First Name Initial	_____	_____
_____ Surname First Name Initial	_____	_____
_____ Surname First Name Initial	_____	_____
_____ Surname First Name Initial	_____	_____

Please note that designating a beneficiary is one of the most important decisions you will make regarding this group Insurance Plan. The Designations that you make should clearly reflect your intentions of who will receive the death benefit proceeds.

If you are designating a beneficiary who is a minor, insurance proceeds cannot be paid directly to him/her. In order to avoid difficulties with settlement of a claim, a trustee should be named for all minor children.

When percentages have been allocated to each beneficiary, only these amounts can be paid to each beneficiary. Should one of the beneficiaries die before you, his/her portion would be made payable to your estate.

PLEASE NOTE: The Trustee Designation is ONLY to be completed when a Named Beneficiary is a minor

Trustee Designation: I hereby appoint _____
Name Relationship
As trustee to received any payments on behalf of _____, the beneficiary that I have designated above during his/her minority.

F. CONSENT, DISCLOSURE, AUTHORIZATION AND ACKNOWLEDGEMENT

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 recognize that in providing service to me in the future and providing me with the benefits included in the Group Benefits Plan I am enrolling in, 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 acknowledge that I only enroll, at this time or any future time, dependents who have authorized me to provide their information and consent to the collection, use and disclosure of that information for the purposes listed above.

You can obtain further information about *Wawanesa Life's Personal Information Protection Policy* from the Wawanesa Life Head Office at 200 – 191 Broadway, Winnipeg, MB, R3C 3P1 or at www.wawanesalife.com.

Authorization & Acknowledgement

I hereby apply for coverage for which I am, or may become eligible under the Group Insurance Plan issued by Wawanesa Life.

I acknowledge that the information provided is complete and accurate.

I authorize the deduction from my pay for any contributions required under the Group Insurance Plan, if required.

I authorize Wawanesa Life, any healthcare provider, my plan administrator, other insurance companies, or benefit providers working with Wawanesa Life to exchange information, when necessary to determine my eligibility for coverage and to administer the Group Insurance Plan.

Date: _____ Signature: _____