



Employee New Change Dependent(s) New Change Beneficiary(s) New Change
If this application is for a change, indicate the effective date: _____
(YY/MM/DD)

EMPLOYEE INFORMATION Please Type or Print Clearly

Employee Name _____
First Name _____ Last Name _____ Initial _____
Mailing Address _____
Street _____ City _____ Province _____ Postal Code _____

Date of Birth _____ Sex Male Female
(YY/MM/DD) Do you have a spouse*? Yes No
Do you have dependent child(ren)? (Under 21 years of age) Yes No
*Common-Law spouse eligible after 12 months of co-habitation Date of Co-habitation: _____

DEPENDENT INFORMATION Please indicate any or all of the following that apply:

I request coverage to be added for my spouse/child(ren) I no longer require coverage for my spouse
 I no longer require coverage for my dependent child I am legally required to continue coverage for my ex spouse.
(Please provide a copy of the court order.)

Add	Delete	Last Name	First Name	Initial	Sex	Birth Date YY/MM/DD
<input type="checkbox"/>	<input type="checkbox"/>	Spouse				
<input type="checkbox"/>	<input type="checkbox"/>	1 st Child				
<input type="checkbox"/>	<input type="checkbox"/>	2 nd Child				
<input type="checkbox"/>	<input type="checkbox"/>	3 rd Child				
<input type="checkbox"/>	<input type="checkbox"/>	4 th Child				
<input type="checkbox"/>	<input type="checkbox"/>	5 th 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.

In situations of divorce or separation, the plan of the parent with custody of the child will assess claims first.
 I wish to co-ordinate family benefits with my spouse's Group Insurance plan.
Spousal Insurer's Name _____ Plan Number _____
 I wish to have single coverage with my employer's Group Insurance plan.

EMPLOYEE NAME CHANGE

From: _____ To: _____
Effective Date: _____ Reason: _____
(YY/MM/DD)

INFORMATION SUPPLIED BY POLICYHOLDER

Date Employed _____ (YY/MM/DD)	Employer Name _____	Policy # _____	Class # _____
Coverage Effective Date _____ (YY/MM/DD)	Employee Occupation _____	Number of Hours worked per week _____	Earnings <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Annually

For Wawanesa Life Head Office Use Only
W.P. _____ Eff. Date _____ R.C. _____



Group Operation
 400-200 Main Street, Winnipeg, MB R3C 1A8
 1-800-665-7076

**Diversity Group Benefits
 Employee Application Form**

Policy # _____ Employee Name _____
Last Name First Name

BENEFICIARY DESIGNATION

Beneficiary's Name(s)		<input type="checkbox"/> New	<input type="checkbox"/> Change		
Last Name	First Name		Initial	% Allocated	Relationship of Beneficiary to Applicant
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
Total				100%	

The employee can designate or change a beneficiary at any time. 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.

You can designate a **Contingent Beneficiary** by attaching a separate page to this application with your instructions and signature.

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.

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. **Please complete the Trustee Designation.**

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 receive any payments on behalf of _____, the beneficiary that I have designated during his/her minority.

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 400 – 200 Main Street, Winnipeg, MB, R3C 1A8 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 _____

Yes, I would like to receive information about Eclipse OnLine and Automatic Deposit for claims reimbursement. Email Address: _____