Evidence of Insurability

This form is used for Late Applicants, and applying for Excess & Optional Coverage

Please return this completed form and supporting documents to:

The Wawanesa Life Insurance Company
Group Benefits Services
236 Carlton Street, Winnipeg, Manitoba R3C 1P5
For Inquiries, please call 1-800-665-7076

Plan Member Instructions

1. Please complete all applicable sections of the form to avoid delays in your application.
   - Late Application:
     - Employee: Complete sections 1 to 4
     - Spouse and/or Child: Complete sections 1 and 5, as well as the Questionnaire on page 7
   - Excess Application:
     - Employee and Spouse: Complete sections 1 to 4
   - Optional Coverage Application:
     - Employee and Spouse: Complete sections 1 to 4
2. Please sign and date your application. Any changes or errors must be initialed and dated.
3. Please remove the Applicant Copy - Notice of Medical Information Bureau Inc. (“MIB Inc.”). This should be given to the customer for their information.
4. To ensure that the information contained in this form is treated in a confidential manner, please send your completed application directly to The Wawanesa Life Insurance Company (“Wawanesa Life”) at the address listed below.
5. If further information is required, we will be in contact with you directly.
6. All information provided by you is located at our Executive Office:

   The Wawanesa Life Insurance Company
   Group Operations
   236 Carlton Street, Winnipeg, Manitoba R3C 1P5

Who is completing this application?

Please complete two separate forms when both you and your spouse are required to complete an Evidence of Insurability form.

Employee - please provide:

Last Name: _____ First Name: _____ Initial: _____

Certificate Number: _____

Spouse - please provide:

(Note: Evidence of Insurability is only required when applying for Optional coverage or Excess coverage.)

Last Name: _____ First Name: _____ Initial: _____

Plan Member Name: _____ Certificate Number: _____

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Section 1 - Plan Sponsor / Employee Identification

Name of Plan Sponsor: _____ Group Plan Number: _____

Employee's Name: _____ Date of Birth (dd/mm/yyyy): _____

Home Address (Street & Number): _____

City: _____ Province: _____ Postal Code: _____

Home Phone Number: _____ Business Phone Number: _____

Occupation, Essential Duties (Include % of time for each duty):

Salary: $_____ Basis: ◯ Annual ◯ Semi-monthly ◯ Monthly ◯ Weekly ◯ Bi-weekly

◯ Hourly (hours per week): _____ ◯ Other (please specify): _____

Hire Date (dd/mm/yyyy): _____ Group Insurance effective date (dd/mm/yyyy): _____

Place of Birth

Province: _____ Country: _____

Gender: ◯ Male ◯ Female Email Address: _____

Section 2 - Applicant's Personal Information

1. Physician's Name (if no physician, please provide the name of doctor and/or clinic you last attended): _____

Physician's Phone Number: _____

Physician's Address (Street & Number): _____

City: _____ Province: _____ Postal Code: _____

Date of Last Visit (dd/mm/yyyy): _____ Reason for visit: _____

Treatment and results: _____

2. Height: _____ ft. _____ in. Current Weight: _____ lbs.

In the past year (if applicable)

Weight Gain: _____ lbs. Weight Loss: _____ lbs.

Reason: _____

3. Have you used any tobacco or nicotine products including cigarettes, cigarillos, colt, cigars, pipes chewing tobacco, snuff, nicotine gum or patches, e-cigarettes, vaporizers, or any form of nicotine substitute in the last 12 months?

◯ Yes ◯ No

If "Yes", how much?

Quantity per week: _____ Type: _____

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4. Have you used marijuana in the last 12 months? ◯ Yes ◯ No

If "Yes", how much?

Quantity: _____ Frequency: _____ Type: _____

5. (a) Do you presently use alcoholic beverages? ◯ Yes ◯ No

If "Yes", how much?

Quantity per week: _____ Type: _____

(b) Have you ever received treatment or been advised to seek treatment or medical advise because of your alcohol usage? ◯ Yes ◯ No

If "Yes"

Type of treatment: _____ When: _____

6. (a) Are you now using or have you ever used illicit drugs? ◯ Yes ◯ No

If "Yes", please provide details:

Type(s)	Usual Quantity	Frequency of Use	Date Last Used (dd/mm/yyyy)

(b) Have you ever received treatment or been advised to seek treatment because of drug usage? ◯ Yes ◯ No

If "Yes"

Type of treatment: _____ When: _____

(c) Do you now or have you ever attended Alcoholics or Narcotics Anonymous meetings (or similar)? ◯ Yes ◯ No

7. (a) Have you ever had your driver's license suspended or revoked? ◯ Yes ◯ No

If "Yes"

Why, when, for how long: _____

(b) Have you ever been charged with driving while impaired? ◯ Yes ◯ No

If "Yes"

When: _____

(c) Have you had more than three (3) driving violations in the last two (2) years? ◯ Yes ◯ No

(d) Have you been charged with wreckless driving in the last 10 years? ◯ Yes ◯ No

8. Do you currently participate in any hazardous sport activity such as, but not limited to, scuba diving, piloting aircraft, sky diving, auto racing, rock climbing, ice climbing? ◯ Yes ◯ No

If "Yes", please provide details:

Type(s)	Frequency	Date Last Participated (dd/mm/yyyy)	Intent to Participate Again
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

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9. Have you:

(a) In the last five (5) years changed your name (marriage, etc.)? ◯ Yes ◯ No

If "Yes", when and provide name changes:

_____

(b) Ever applied for or received benefits, compensation, or pension because of illness or injury? ◯ Yes ◯ No

If "Yes", why, when, duration and type of benefit:

_____

(c) Ever had an application for Life, Disability, or Health Insurance declined, postponed, or rated or modified in any way? ◯ Yes ◯ No

If "Yes", why, when, and what:

_____

(d) In the last five years been absent from work for more than seven (7) consecutive days for medical reasons? ◯ Yes ◯ No

If "Yes", why, when, duration:

_____

Section 3 - Applicant's Personal Medical Information

For questions answered "Yes", highlight or circle the appropriate disorder and give details in section 4.

10. Has any family member (whether now living or deceased) ever suffered from, or is suffering from High Blood Pressure, Heart Disease, Stroke, Cancer or any other tumor (specify type of cancer or tumor), Diabetes, Polycystic or other Kidney Disease, Mental Illness, Huntington's Disease, Motor Neuron Disease (including ALS/Lou Gehrig's Disease), Muscular Dystrophy, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease, or any other hereditary disease?

◯ Yes ◯ No

Please complete the following chart for ALL family members:

	Disease	Age at Diagnosis	Actual Age, if Alive	Condition, if Alive	Age at Death	Cause of Death
Father						
Mother						
Brother (1)						
Brother (2)						
Sister (1)						
Sister (2)						

11. Have you ever been treated for, been advised to seek advice or treatment for, or had any known indication of, or any disorder of:

(a) **The Ears, Eyes, Nose, Throat, Lungs:** Including blood spitting, tuberculosis, pleurisy, shortness of breath, persistent cough, asthma, bronchitis, COPD, emphysema, impairment of hearing, speech or sight?

◯ Yes ◯ No

(b) **The Heart, Arteries or other parts of the Circulatory System:** Including angina, chest pain, elevated cholesterol, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, peripheral vascular disease, or abnormal ECG?

◯ Yes ◯ No

(c) **The Gastrointestinal System:** Including ulcer, hernia, colitis, gallstones, Crohn's disease, diverticulitis, hepatitis, jaundice, liver disease, chronic diarrhea, pancreatic disease, or intestinal polyps?

◯ Yes ◯ No

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(d) **The Kidneys, Bladder, Reproductive System:** Including blood or pus or sugar or albumin in urine, stones, sexually transmitted disease, abnormal pap smear or prostate disease?

◯ Yes ◯ No

(e) **The Brain and Nervous System:** Including epilepsy, seizures, convulsions, stroke, transient ischemic attack (TIA), multiple sclerosis, numbness or tingling of limbs, dizziness or fainting spells, paralysis, Alzheimer's, Parkinson's, Huntington's, motor neuron disease (including ALS/Lou Gehrig's disease), coma, head injury, persistent headaches, depression, anxiety, adjustment disorder, fatigue, nervous breakdown, emotional or nervous disorder?

◯ Yes ◯ No

(f) **The Blood and Glands:** Including anemia, diabetes, leukemia, gout, allergy, night sweats, enlargement of lymph nodes (glands), breast disorder, pituitary disorder, thyroid disorder, unusual skin lesions or disorders or unexplained infections?

◯ Yes ◯ No

(g) **The Musculo-Skeletal System:** Including arthritis, disease disc (herniated or ruptured disc), back or neck pain, knee problems, whiplash, rheumatism, lupus, paralysis, deformity, amputation or any other disease, injury or deformity of the spine, joints, bones or muscles including fibrositis or fibromyalgia?

◯ Yes ◯ No

(h) **The Immune System:** Including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (A.R.C), positive HIV test or any other immunological disorder?

◯ Yes ◯ No

(i) Cysts, tumors, cancer, polyps, mole, lump or other growths, breast disorder or unusual discharge or abnormal mammogram or biopsy?

◯ Yes ◯ No

12. Other than as disclosed in the answers above, have you:

(a) In the last five (5) years consulted with a physician, medical practitioner, or chiropractor? ◯ Yes ◯ No

(b) Consulted or been referred to a physician or medical practitioner for any illness or injury which has not yet been diagnosed or treated, for which testing/ investigation is pending or in progress, for which you have been advised to seek treatment? ◯ Yes ◯ No

(c) In the last five (5) years had an ECG, blood test or other diagnostic tests? ◯ Yes ◯ No

(d) Ever been tested for exposure to the AIDS virus? ◯ Yes ◯ No

(e) Noticed any symptoms or health problems for which you have not yet consulted a physical or medical practitioner? ◯ Yes ◯ No

(f) Are you currently under any treatment or medication? ◯ Yes ◯ No

(g) Any outstanding test results? ◯ Yes ◯ No

(h) Had any menstrual disturbance or complicated pregnancy? ◯ Yes ◯ No

(i) Are you pregnant? ◯ Yes ◯ No **If "Yes"**, provide expected date of delivery (dd/mm/yyyy): _____

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Section 4 - Applicant's Personal Medical Information Details

Details of any "Yes" answers to questions 10-12

For all "Yes" answers to Personal Medical Information, use the following section if required to provide details:

Question Number	Diagnosis / Reason; Symptoms, Test Pending / Results, Treatment	Date (dd/mm/yyyy)	Name and Address of Physician and/or Hospital

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Section 5 - Spouse & Dependent Information

(Only required when applying as a late applicant)

Spouse

Last Name: _____ First Name: _____ Date of Birth (dd/mm/yyyy): _____

Home Address (Street & Number - if different from Employee's): _____

City: _____ Province: _____ Postal Code: _____

Dependent 1

Last Name: _____ First Name: _____ Date of Birth (dd/mm/yyyy): _____

Home Address (Street & Number - if different from Employee's): _____

City: _____ Province: _____ Postal Code: _____

Dependent 2

Last Name: _____ First Name: _____ Date of Birth (dd/mm/yyyy): _____

Home Address (Street & Number - if different from Employee's): _____

City: _____ Province: _____ Postal Code: _____

Dependent 3

Last Name: _____ First Name: _____ Date of Birth (dd/mm/yyyy): _____

Home Address (Street & Number - if different from Employee's): _____

City: _____ Province: _____ Postal Code: _____

Questionnaire

	Spouse	Dependent 1	Dependent 2	Dependent 3
1. Within the last two years have you had a stroke, heart attack or been advised to have heart surgery?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Within the last three years have you had any indication of, consulted a physician for, or received treatment for cancer?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Within the last three years have you been declined for individual insurance by any insurer?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you been diagnosed, treated for, or had any indication of AIDS or AIDS related complex?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
5. Are you currently restricted to a wheelchair, bedridden, hospitalized or confined to a nursing facility?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Please note that the signature section for this application is on page 9.

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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 (“Wawanesa Life”) its reinsurers or its Associates for the purposes of administering my application for coverage under this group plan.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during my coverage under this plan, with the insurer’s 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 understand that by furnishing this form and investigating the eligibility for coverage. 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 under the plan.

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 who require this information to perform their jobs; claims investigators, investigative agencies, regulatory bodies, 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 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. I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the coverage being applied for.

You can obtain further information about Wawanesa Life’s Personal Information Protection Policy and practices concerning service providers outside Canada from www.wawanesalife.com or from our Customer Service Department, Wawanesa Life, 236 Carlton St, Winnipeg, MB R3C 1P5.

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, 236 Carlton St, Winnipeg, MB R3C 1P5.

Declaration & Signature

I hereby apply for group coverage under the group insurance plan issued to my Plan Sponsor or my spouse's Plan Sponsor by The Wawanesa Life Insurance Company and agree that the insurance will not commence until this application is approved by The Wawanesa Life Insurance Company. I hereby acknowledge that the answers recorded are given by me and are complete and true. They shall be part of any contract issued by The Wawanesa Life Insurance Company. I acknowledge receipt of the notice regarding the MIB Inc. and Investigative Reports, and consent to such reports being obtained by Wawanesa Life.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the MIB Inc., Motor Vehicle Department concerning driving records, or other organization, institution or person that has any records or knowledge of me or my 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 coverage. I authorize the Medical Director of Wawanesa Life to release all medically related information obtained during the underwriting process to my personal physician or other medical practitioner.

A photographic copy of this authorization shall be as valid as the original.

☐ *I declare that the answers provided in Section 5 and the questionnaire for my dependent children (if applicable) are complete and accurate to the best of my knowledge, and these answers will be part of the insurance application.

Date (dd/mm/yyyy): _____ Employee Signature: _____

Date (dd/mm/yyyy): _____ Signature of Spouse (if applicable): _____

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Evidence of Insurability

Applicant Copy

This notice must be detached and given to the Applicant

Notice of Medical Information Bureau Inc. (“MIB Inc.”)

Information regarding your insurability will be treated as confidential. Wawanesa Life or its reinsurers may, however, make a brief report thereon to the MIB Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB Inc. will arrange disclosure of any information it may have in your file. Please contact MIB Inc. at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB Inc.’s file, you may contact MIB Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB Inc. information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-87.

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

In the processing of the application for insurance, The Wawanesa Life Insurance Company may obtain Motor Vehicle Reports, a personal investigation or consumer reports containing personal information about the applicant.