



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

**Diversity Basic & Diversity Enhanced**  
**Employee Application Form**

**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 \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth _____ (YY/MM/DD)	Sex <input type="checkbox"/> Male	Do you have a spouse*?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Female	Do you have dependent child(ren)? (Under 21 years of age)	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <sup>st</sup> Child					
<input type="checkbox"/>	<input type="checkbox"/>	2 <sup>nd</sup> Child					
<input type="checkbox"/>	<input type="checkbox"/>	3 <sup>rd</sup> Child					
<input type="checkbox"/>	<input type="checkbox"/>	4 <sup>th</sup> Child					
<input type="checkbox"/>	<input type="checkbox"/>	5 <sup>th</sup> Child					

**Other Insurance:**

- I choose single coverage because my spouse and/or dependent(s) are covered under another Insurance plan.

Spouse's Insurer's Name \_\_\_\_\_ Plan Number \_\_\_\_\_

- I choose family coverage and want to coordinate with my Spouse's Insurance plan.

**Coordination 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). Total payments under all plans will 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.

**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. \_\_\_\_\_



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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
_____	_____			_____	_____	_____
_____	_____			_____	_____	_____
_____	_____			_____	_____	_____
_____	_____			_____	_____	_____
<b>Total</b>					<b>100%</b>	

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](http://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: \_\_\_\_\_