Group Operation
400 – 200 Main Street, Winnipeg, MB R3C 1A8

Alternate Coverage Information

EMPLOYER/EMPLOYEE IDENTIFICATION

Policy #: G Employer Name: _____ Claimant ID#: WLI

Employee Name: _____ _____
First Name Last Name

This form must be completed in conjunction with the Notice of Change form to ensure full details of dependents are provided.

☐ Alternate coverage has now terminated. Coverage under Wawanesa Plan for Health, Vision and/or Dental Benefits was previously waived.

☐ Alternate coverage is still in effect. Application is being made to Wawanesa Life to provide additional coverage.

Coverage required for: Health ☐ Vision ☐ Dental ☐

The following information is required to apply for coverage at this time:

1. The reason the employee and/or his dependents are no longer covered under an alternate policy.

2. The date that the alternate coverage terminated. _____

3. The name and address of the employer where alternate coverage was provided (if covered through a plan at work).

4. The insurance company name and the policy number of the terminated or alternate plan(s).

5. Benefits that the employee and/or his spouse had through the terminated plan:
   - ☐ Health
   - ☐ Vision
   - ☐ Dental
   - ☐ Other (List): _____

_____ _____
Signature of Insured Member Date

For Wawanesa Life Head Office Use Only

Alternate Coverage Terminated/COB Updated Date: _____