Overage Disabled Dependent Application Form

Please return this completed form to the address below. Alternatively, you can email your application to MRT@wawanesa.com for a faster response.

The Wawanesa Life Insurance Company
Group Benefits Services
236 Carlton Street, Winnipeg, Manitoba R3C 1P5
MRT@wawanesa.com

Dependent Child Eligibility

The Plan Member applies to Wawanesa Life for continuation of insurance beyond the termination age specified in the Policy with respect to the child below who otherwise qualified as a Dependent Child as defined in the Policy. The named Dependent Child became incapable of engaging in self-sustaining employment due to a mental or physical disability incurred prior to age 21, or between the ages of 21 and 25 while a full-time student at an accredited school, college, or university, and is dependent upon the Plan Member for support and maintenance.

I understand that coverage is subject to approval by The Wawanesa Life Insurance Company and that continuous coverage is subject to written request for the insurance having been made within 31 days from the date the child attains the termination age specified in the policy.

I also understand that any charge by the physician for completing their portion of this application is to be paid by me.

Plan Member Information

Plan Sponsor Name: _____ Group Plan Number: _____

Plan Member First Name: _____ Plan Member Last Name: _____

Certificate Number (Insurance ID Card): WLI: _____ Date of Birth (dd/mm/yyyy): _____

Effective Date of Coverage with Wawanesa Life (dd/mm/yyyy): _____

Plan Member Address: _____

City: _____ Province: _____ Postal Code: _____

Plan Member Telephone Number: _____ Plan Member Email: _____

Dependent Child Information

Dependent Child First Name: _____ Dependent Child Last Name: _____

Dependent's Date of Birth (dd/mm/yyyy): _____ Dependent Child Address - same as member: ◯ Yes ◯ No

Dependent's Address (if applicable): _____

City: _____ Province: _____ Postal Code: _____

Has your Dependent Child ever been employed? ◯ Yes ◯ No If yes, most recent dates: _____

How many hours per week? _____

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Privacy Notice and Consent

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 authorize the below physician who has attended the Dependent Child named above to disclose any information regarding the child's personal history, physical or mental medical impairment to The Wawanesa Life Insurance Company.

I consent to The Wawanesa Life Insurance Company collecting, using and disclosing the personal information of my Dependent Child and myself for the purposes of establishing and maintaining communications; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services; compiling statistics and acting as required or authorized by law.

I understand that The Wawanesa Life Insurance Company may share the personal information with the following people, organizations and service providers: The Wawanesa Life Insurance Company employees and agents who require this information to perform their jobs; claims investigators, investigative agencies, 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 the personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. The personal information may be shared as required by the laws of those jurisdictions.

I understand that any restriction or withdrawal of my consent may result in The Wawanesa Life Insurance Company being unable to process the claim being applied for.

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 a complaint regarding our privacy policies or procedures, or would like to obtain further information please review the Privacy Policy www.wawanesalife.com or contact the Privacy Office at: privacy@wawanesa.com

I hereby acknowledge that the above is complete and accurate.

Plan Member's Signature: _____ Date Signed (dd/mm/yyyy): _____

Attending Physician Statement (to be completed by Physician)

1. What is the Dependent Child's medical diagnosis causing functional impairment? _____

2. When was the diagnosis made (dd/mm/yyyy)? _____

3. Is it Permanent or Temporary? ◯ Permanent ◯ Temporary

4. Please describe the nature and degree of the mental or physical functional impairment:

5. To what degree does the mental or physical impairment prevent the Dependent Child from performing their normal everyday activities?

Physician's Name: _____ Physician's Signature: _____

Physician's Address: _____

City: _____ Province: _____ Postal Code: _____

Date Signed (dd/mm/yyyy): _____ Physician's stamp:

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