Diversity Basic & Diversity Enhanced
Master Application

Policy Effective Date Requested

____ / ____ / ____ Year Month Day	(TO BE COMPLETED BY WAWANESA LIFE) Group Policy Number G- ______

Employer Information

Name of Business	Nature of Business

Business Address	City	Province	Postal Code

Phone Number	Fax Number	PAD* Y / N	Eclipse OnLine** Y / N	E-Mail

****Pre-Authorized Debit** – if requested, please complete the application including Void cheque (Page 4)*
*****Eclipse OnLine** – if requested, please complete and attach an application and agreements (http://www.wawanesalife.com/group-eclipse-online.asp)*

Legal Status of Applicant

- ☐ Corporation
- ☐ Partnership
- ☐ Sole Proprietorship
- ☐ Union
- ☐ Association
- ☐ Other ______________

Please indicate who can make binding changes to this plan on behalf of the employer.

______________________ ______________
Name of Key Employee Title

______________________ ______________
Name of Plan Administrator Title

Subsidiary or Affiliated Companies to be Covered: (SUBJECT TO APPROVAL BY WAWANESA LIFE)

Name	Address	Nature of Business

General Information

Class	Diversity Basic or Diversity Enhanced***	Description of Class	Minimum # of Hours per Week	Is this class Unionized (Y or N)
1	Diversity Basic		24	
2	Diversity Enhanced		24	

***If Diversity Enhanced is selected, all employees enrolled in this class must have a minimum annual salary of $25,000

Are there any employees absent from work on the requested effective date of this policy?

☐ Yes ☐ No If yes, please complete the information requested below:

If a claim has been filed with the prior carrier, attach the letter approving or declining the claim.

Employee Name	Date Last Worked	Expected Return to work date	Reason for absence (maternity leave, sickness, other..)

Are 100% of employees enrolled in this plan? ☐ Yes ☐ No
If no, list any employees not covered by this plan and the reason why:

Feature	☐ Basic	☐ Enhanced
Life Insurance		
Benefit Amount	$25,000	$50,000
Conversion	Yes	Yes
Termination	Earlier of retirement or age 70	Earlier of retirement or age 70
Accidental Death Insurance		
Benefit Amount	$25,000	$50,000
Termination	Earlier of retirement or age 70	Earlier of retirement or age 70
Long Term Disability		
Benefit Amount per month	$750	Without Evidence $1,500 (minimum salary of $25,000/year) With Evidence $2,500 (minimum salary of $45,000/year)
Maximum LTD Benefit Period	5 years	5 years
Termination Age	65	65
Qualifying Period	120 days	120 days
Pre-existing Clause	6/12 months	6/12 months
Definition of Disability	5 year own occupation	5 year own occupation
Critical Illness (one payment per lifetime)	$1,000	$1,500
Benefit Offset	N/A	Primary CPP/QPP, WCB, EI and any government plan of insurance including auto
Termination Age	Earlier of retirement or age 65 minus qualifying period	Earlier of retirement or age 65 minus qualifying period
Extended Health Benefit		
Reimbursement	80%	90%
**Drugs (Pay Direct Drug Card) **	$5,000 maximum	$10,000 maximum
Paramedical Services	$800 maximum combined	$1,000 maximum combined
Medical Supplies	$1,500 maximum	$2,000 maximum
Termination Age	Age 70	Age 70
Reimbursement	100%	100%
Ambulance (Ground)	$500 per year	$500 per year
Hospital Semi-Private	$500 per year	$1,000 per year
Termination Age	Age 70	Age 70
Vision		
Reimbursement	N/A	100%
Frames, Lenses & Contacts	N/A	$150 per 24 months
Termination Age	N/A	Age 70
Dental		
Basic Reimbursement	80%	90%
Major Reimbursement	N/A	50%
Annual Maximum	$1,000	$1,500 (Basic & Major combined)
9 months recall	Yes	Yes
Scaling	10 units per calendar year	10 units per calendar year
Fee Guide	General Practitioner	General Practitioner
Termination Age	Age 70	Age 70

****Note: Maximums will be reduced by 50% in the first calendar year for groups with an effective date from July 1 through December 31 for all Dental, Drugs, Paramedical and Medical Supplies & Services.**

Cost Sharing (Employer Contributions)

The employer is contributing __________ % of the premiums.

If greater than “85%”, Long Term Disability benefits are taxable.

Change of Insurer

(This Section can be omitted if group has no prior coverage)

Copy of prior carrier’s billing and booklet is required		
Name of Prior Carrier	Effective Date	Termination Date

Grandfathering – *subject to approval by Wawanesa Life*

For Diversity Enhanced only, the following employees wish to grandfather their LTD coverage allowing a change from the current $1,500 to $2,500 benefit level. They currently have annual salaries equal to or greater than $45,000 and were insured by the above named prior carrier for LTD volumes in excess of $2,500:

Employee Name	Amount Shown on Prior Carrier Billing	Date the employee was last Medically Underwritten

If the above is different from information provided at time of quote, Wawanesa Life reserves the right to refuse this application

Sold Rates – Attach completed Diversity Quote Sheet

Declaration

The employer hereby declares that to the best of his/her knowledge all statements and answers contained herein are full, complete and true as of the date this Application for Group Insurance is signed and agrees that:

a) The Application will form part of the Policy between the Applicant and Wawanesa Life, and
b) The premium rate table will form part of the Policy between the Applicant and Wawanesa Life, and
c) The Policy will not become effective until this application and rate table have been accepted and approved by the Head Office of The Wawanesa Life Insurance Company.

Dated at ________ Date ________ Applicant ________ $ ________ Premium Deposit

Witness ________ Authorized Signature and Title ________

Approval

Wawanesa Life hereby declares that this application and any addendums or attachments herein are accepted and shall form a part of the Group Insurance contract as of the Effective Date stated on page 1 of this application.

Dated at ________ Date ________

Dawn Smook
Manager, National Group Sales & Marketing

Important

Please ensure that the following documents are included with this application:

- ☐ Cheque for first month’s premium
- ☐ Employee applications
- ☐ PAD application
- ☐ Previous carrier’s bill and booklet, if applicable
- ☐ The Wawanesa Life copy of the Diversity Quote Sheet
- ☐ Eclipse OnLine Agreement and Application

GROUP APPLICATION FOR OR CHANGE TO PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

This agreement is for (check one): ☐ NEW PAD ☐ ADDITION TO EXISTING PAD ☐ CHANGE TO PAD/BANK INFORMATION

PAYOR INFORMATION (please print clearly)

POLICYHOLDER ______ PHONE # ______

STREET ADDRESS ______

CITY AND PROVINCE ______ POSTAL CODE ______

BANK ACCOUNT INFORMATION

PLEASE ATTACH A SAMPLE CHEQUE MARKED 'VOID' and/or complete the following:

NAME OF ACCOUNT HOLDER ______

FINANCIAL INSTITUTION (F.I.) ______

BRANCH ADDRESS ______

CITY AND PROVINCE ______ POSTAL CODE ______

TYPE OF ACCOUNT (must allow electronic debits) ☐ SAVINGS ☐ CHEQUING

TRANSIT NO. ______ F.I. NO. ______ ACCOUNT NO. ______

PAD DETAILS: All Group Premiums will be withdrawn on the 1st of each month, or the next business day, according to the Balance Due on the most recent billing statement.

Group Policy #	Group Account #	Name of Group Policyholder

FOR HEAD OFFICE USE ONLY
PAD No.
First Withdrawal Date

CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

We consent to Wawanesa Life collecting, using and disclosing our personal information for the purposes of: receiving payments on account of insurance premiums, depositing funds into our account; establishing and maintaining communications with us; detecting and preventing fraud; compiling statistics and acting as required or authorized by law.

Further information about Wawanesa Life's Personal Information Protection Policy can be obtained from the Wawanesa Life Head Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

AUTHORIZATION AND SIGNATURES

The Wawanesa Life Insurance Company is requested and authorized to make monthly withdrawals from the account designated above or from any subsequently designated account in order to make Group Premium payments, under the following terms:

1. Withdrawals are to be made for Business purposes only.
2. You, the Payor, may revoke your authorization at any time, subject to providing written notice of ten (10) days to Wawanesa Life. For more information on your right to cancel a PAD Agreement, contact your financial institution or visit www.cdnpay.ca.
3. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. For more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.
4. You, the Payor, should keep a copy of this PAD Agreement for your records and a signed paper or electronic copy should be sent to Wawanesa.

______ Authorized Signature for the Account | ______ Name of Signing Authority (please print) | ______ Date

______ Additional Authorized Signature for the Account (if applicable) | ______ Name of Other Signing Authority (please print) | ______ Date

PLEASE RETURN FORM TO:
Wawanesa Life – Group Operation
400 – 200 Main Street
Winnipeg, MB R3C 1A8

CONTACT INFORMATION:
Tel. 1.800.665.7076
Fax. 204.985.5781
Email. GCS@wawanesa.com