Wawanesa Life
Group Division
400-200 Main Street
Winnipeg, Manitoba
R3C 1A8

DIVERSITY

EMPLOYER APPLICATION

Please complete this Application in full and attach payment representing one month of premium. The approval of this application is subject to Head Office review.

Thank you for choosing Wawanesa Life

as your Group Insurance provider.

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 and attach an application including Void cheque*
****Eclipse OnLine*** *– if requested, please complete and attach an application and agreements*

Legal Status of Applicant

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

Please indicate who can make changes to this plan and thereby bind the employer to these changes.

_____ _____
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	Description of Class	Is this class Unionized (Y or N)	Minimum Number of Hours per Week	Notes

Are there any employees absent from work on the 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%	100%
Drugs (Pay Direct Drug Card)	$5,000 maximum	$10,000 maximum
Paramedical Services	$750 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%	100%
Major Reimbursement	N/A	50%
Annual Maximum	$1,000	$1,500 (Basic & Major combined)
6 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

Cost Sharing (Employer Contributions)

The employer is contributing _____ % of the premiums.

*if greater than "70%", 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 group policy or booklet to be attached

Name of Prior Carrier	Effective Date	Termination Date

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 2 of this application.

Dated at	Date	Authorized Signature and Title

Important

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

- ☐ Cheque for first month's premium
- ☐ Employee applications
- ☐ Previous carrier's bill or booklet, if applicable
- ☐ The Wawanesa Life copy of the Diversity Quote Sheet