Wawanesa Life

APPLICATION FOR QUICK ISSUE CRITICAL ILLNESS

GENERAL INFORMATION - INSURED

LIFE INSURED (PRINT)

DATE OF BIRTH: DAY / MONTH / YEAR

AGE

SEX ☐ M ☐ F

LIFE INSURED ADDRESS – NUMBER, STREET, CITY, PROVINCE

OCCUPATION

PLACE OF BIRTH: PROVINCE: COUNTRY:

Has there been a change of name in the last five years? Yes ☐ No ☐ If YES: ____________________

Are you a Canadian citizen or landed immigrant? Yes ☐ No ☐ **If NO, coverage is not available.**

GENERAL INFORMATION - POLICYOWNER

POLICYOWNER, if other than Life Insured (PRINT) ☐ MR. ☐ MRS. ☐ MISS ☐ MS.

SOCIAL INSURANCE NUMBER

POLICYOWNER ADDRESS – NUMBER, STREET, CITY, PROVINCE

POSTAL CODE

POLICYOWNER OCCUPATION

RELATIONSHIP TO INSURED

BENEFICIARY

In the event of death of the Life Insured, the beneficiary will be:

IDENTITY VERIFICATION

For each Insured and Owner, please submit one of the following*:

- Personal cheque (for the initial premium), or
- Pre-Authorized Debit agreement (if premiums will be paid via PAD), or
- From the **original** identity document (i.e. birth certificate, driver's license, passport etc.), complete details in the chart provided.

	Life Insured	Policyowner(s)
Document Type:		
Document No.:		
Jurisdiction:		

* **Note: These requirements apply if the advisor has personally met the client; otherwise, non face-to-face FINTRAC requirements apply.**

Additional Requirements for Corporations and other Entities:

1. **Confirming existence** – existence must be confirmed by referring to the following documents:
   - **For corporations**: certificate of corporate status, a record that has to be filed annually under the provincial securities legislation, or any other record that ascertains its existence as a corporation (e.g. Income Tax Return).
   - **For other Entities**: partnership agreement, articles of association or other similar record.

   A copy of the confirming document must be forwarded to Wawanesa Life for record keeping.
2. **Obtaining beneficial ownership information** – the following information must be obtained and sent to Wawanesa Life:
   - Name and occupation of all directors of the corporation, and
   - Name, address and occupation of all individuals who directly or indirectly own or control 25% or more of the shares of the corporation/entity.

Not-for-Profit Organizations (in addition to the above):

Is the entity a registered charity for income tax purposes? Yes ☐ No ☐

If NO, does the entity solicit charitable donations from the public? Yes ☐ No ☐

DETAILS OF POLICY BENEFITS

Basic Amount $ ______

☐ T10 Renewable to 75

☐ Level Term to 75

☐ Level Term to 75 / ROP

PAYMENT OPTIONS

☐ PRE-AUTHORIZED DEBIT*: ☐ Monthly ☐ Semi-Annual ☐ Annual

or ☐ Billing: n/a ☐ Semi-Annual ☐ Annual

Please complete Pre-Authorized Debit Agreement on page 4.

TOBACCO USE

Within the last 12 months, have you used any tobacco or nicotine products including cigarettes, cigarillos, colts, cigars, pipes, chewing tobacco, snuff, nicotine gum or patches, or any form of nicotine substitute, or marijuana? ☐ Yes ☐ No

POLICY DELIVERY OPTIONS

Policy should be mailed to: ☐ Policyowner (direct delivery) or ☐ Agent (personal delivery)

If no preference is indicated, policy will be sent directly to the policyowner.

Wawanesa Life

QUALIFYING QUESTIONS

1. Within the last two years, have you had an application for individual life insurance or critical illness insurance rated, declined, postponed or had exclusions added by Wawanesa Life or any other company? ☐ Yes ☐ No

2. Have you ever been treated for, diagnosed, consulted a doctor, received abnormal test results or experienced symptoms of the following: ☐ Yes ☐ No
   - (a) Heart attack, congenital cardiac defects, angina, angioplasty, coronary artery bypass, congestive heart failure, stroke, transient ischemic attack (TIA), arteriosclerosis or any other cerebrovascular disease or disease of the heart or the blood vessels, or an abnormal electrocardiogram (EKG)?
   - (b) Type 1 (insulin-dependent) diabetes or type 2 diabetes?
   - (c) Cancer or other malignant disease, growth, tumour or colon polyp?
   - (d) Multiple Sclerosis or motor neuron disease?
   - (e) Any breast disorders (mass, cyst, unusual discharge, physical change, abnormal mammogram or biopsy) or prostate disorders (nodule or abnormal PSA)?
   - (f) Any eye or ear problems or diseases other than corrected by glasses, contact lenses or hearing aids?

3. (a) Have you consulted a physician for an illness or condition which has not yet been diagnosed or for which testing is still in progress? ☐ Yes ☐ No
   (b) Have you noticed any symptoms or health problems for which you have not yet consulted a physician, such as: lump or mass of the breasts, shortness of breath, chest pain, dizziness, loss of balance, numbness, rectal bleeding, prostate or other problems?

4. Have you ever tested positive for HIV or been diagnosed, treated for or had any indication of AIDS, AIDS related complex, liver or kidney failure, cirrhosis, chronic kidney disease, hepatitis B or C, or carrier of hepatitis B? ☐ Yes ☐ No

5. Within the last five years, have you received treatment or been advised to seek treatment or medical advice because of your alcohol usage? ☐ Yes ☐ No

6. Within the last five years, have you used: heroin, cocaine, hallucinogens or any other hard drugs other than as prescribed by a doctor, or methadone whether prescribed by a doctor or not, or have you received treatment or been advised to seek treatment or medical advice because of your drug usage? ☐ Yes ☐ No

7. To the best of your knowledge, has one of your natural parents or siblings ever suffered from, or are suffering from heart disease, cancer, stroke or transient ischemic attack (TIA) prior to the age of 55? ☐ Yes ☐ No

8. Does your weight exceed the weight indicated in the maximum weight table below? ☐ Yes ☐ No

Height		Weight	
Ft. in.	cm.	Pounds	Kg
5'0" – 5'3"	150-162	200	91
5'4" – 5'6"	163-169	230	104
5'7" – 5'9"	170-177	250	113
5'10" – 6'0"	178-183	275	125
Over 6'0"	Over 183	290	132

IF YOU ANSWERED 'YES' TO ANY OF THE ABOVE EIGHT QUESTIONS, COVERAGE IS NOT AVAILABLE.

Note: Wawanesa Life reserves the right to carry out an assessment on factors other than the ones indicated above. Wawanesa Life also has a right to obtain a report from The Medical Information Bureau and, should this report be unfavorable, any premiums paid with the application will be refunded and coverage will not be in force during the investigation period.

ALLOCATION OF THIS SALE

		ALLOCATION FACTORS FIRST YEAR	RENEWAL
Charles Taub AGENT OF RECORD (Please print)	C9074 BROKER NUMBER	100 %	100 %
Charles Taub SERVICING AGENT (Please print)	C9074 BROKER NUMBER	100 %	100 %
OTHER (Please print)	BROKER NUMBER	%	%

Wawanesa Life

AGREEMENTS AND AUTHORIZATIONS

I, the Life Insured/Policyowner understand and agree that:

1. Once the policy is issued and mailed/delivered to the Policyowner, the Policyowner will inspect the policy to verify that its terms are satisfactory and as requested. If the policy is not returned to Wawanesa Life within 30 days from the date the policy is mailed/delivered, the Policyowner accepts the policy.
2. No statement, representation or promise made in respect of the insurance applied for shall be deemed to have been communicated to or binding on Wawanesa life unless set out in this application.
3. No agent is authorized to amend, alter, modify or waive the terms of this application, or any contract of insurance issued.

I declare that the statements and answers made in this application and in any supplement to this application are true, complete and correctly recorded and will form the basis of any contract issued.

I acknowledge having received the notices regarding The Medical Information Bureau and Investigative Reports, and consent to such reports being obtained by Wawanesa Life. Should an unfavorable report be obtained from The Medical Information Bureau, any premiums paid with the application will be refunded and coverage will not be in force during the investigation period.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, The Medical Information Bureau, Motor Vehicle Department concerning my drivers abstract, or other organization, institution or person that has any records or knowledge of me or my health or of my children or their health to give Wawanesa Life or its reinsurer(s) any such information. I authorize Wawanesa Life to perform such tests, examinations, x-rays, electrocardiograms, urinalysis, general blood profiles including blood tests for AIDS as may be required to medically underwrite this application for insurance.

I authorize the Medical Director of Wawanesa Life to release all medically related information obtained during the underwriting process to my personal physician or other medical practitioner. I authorize Wawanesa Life to disclose information regarding the underwriting factors, if applicable, to my Wawanesa Life advisor/broker.

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; receiving payments of insurance premiums and policy loan repayments; depositing funds into my account; 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 services to me in the future and providing me with the benefits included in the policy I am applying for, 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.

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.

PRE-AUTHORIZED DEBIT (P.A.D.) PLAN AUTHORIZATION (if applicable)

I request and authorize Wawanesa Life to make withdrawals from the account designated on page 4 of this application or from any subsequently designated account in order to make policy payments and/or specific payments on loan indebtedness, under the following terms:

1. Withdrawals will be made according to the payment frequency indicated on the application on the policy issue date unless a particular withdrawal day is specified.
2. If a monthly PAD is returned as insufficient funds, the next PAD amount will be for the two months of premium. Notification will be provided prior to this double withdrawal.
3. I may revoke my authorization at any time, subject to providing written notice of 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.)*
4. I have certain recourse rights, provided under the personal PAD agreement, if any debit does not comply with the agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with the personal PAD agreement. *(For more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.)*
5. I may provide written request to add/delete policies to the PAD agreement or change bank information without completing a new PAD agreement.
6. **I waive the right to receive 10 days' notice of an increase or decrease in the amount of the automatic withdrawal due to premium changes during the underwriting process. Notification of premium changes will be provided when the policy is issued.**

SIGNATURES

Signed at ____________________ in the province of ____________________ on this ______ day of __________, __________.

____
LIFE INSURED (Signature)

____
POLICYOWNER, if other than Life Insured (Signature)

____
PAD ACCOUNT HOLDERS, if other than the Policyowner or Life Insured (Signature)

____
ADVISOR/BROKER (Signature)

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

You, the Payor, authorize the Wawanesa Life Insurance Company to debit the bank account identified below for the amount, frequency and on withdrawal day indicated or the next business day. For provisions of this agreement, please see the Pre-Authorized Debit Authorization section on page 3.

PAYMENT FREQUENCY (check one)	TOTAL MODAL PREMIUM	WITHDRAWAL DAY
☐ MONTHLY ☐ SEMI-ANNUAL ☐ ANNUAL	$ ____________	☐ POLICY DATE OR ☐ ________ (1ST – 28TH)

PAYOR INFORMATION (please print clearly)

ACCOUNT OWNER NAME(S)* ____________ PHONE # ____________

STREET ADDRESS ____________

CITY AND PROVINCE ____________ POSTAL CODE ☐☐☐☐☐☐

BANK ACCOUNT INFORMATION

☐ Use my current Wawanesa Life PAD under policy # ____________ or PAD # ____________

☐ Establish a new PAD using: ☐ Details from premium cheque (attached) ☐ Details from void cheque (attached) ☐ Information provided below:

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. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

* **Note: Account Owner's signature is required on page 3.**

FOR HEAD OFFICE USE ONLY	
PAD NO.	
TOTAL PAD AMOUNT $	
WITHRAWAL DAY	

Wawanesa Life

APPLICATION FOR INSURANCE CUSTOMER COPIES

ADVISOR / BROKER PROCEDURES

THE PAGES LABELED CUSTOMER COPIES 1 AND 2 MUST BE GIVEN TO THE APPLICANT.

NOTICES & DISCLOSURE STATEMENTS

Receipt for Payment
Receipt for Payment must be completed and given to every applicant.

Advisor/Broker Disclosure Statement
This section must be completed and signed by the selling advisor/broker.

The Notice of Medical Information Bureau (MIB)
This notice must be given to every applicant.

The Notice of Consent to Obtain & Release Medical/Underwriting Information
This notice must be given to every applicant.

The Notice of Consent & Disclosure Regarding Personal Information
This notice must be given to every applicant.

Change in Insurability
This notice must be given to every applicant.

RECEIPT FOR PAYMENT

RECEIVED $ ______________ FOR LIFE INSURANCE APPLIED FOR IN AN APPLICATION WITH THE SAME DATE AS THIS RECEIPT,

ON THE LIFE OF ____

DATE ______________________ SIGNATURE OF ADVISOR/BROKER ______________________

ADVISOR/BROKER DISCLOSURE STATEMENT

The following disclosure notice must be completed by the advisor/broker and provided to you, in writing prior to you entering into this financial transaction. Please ask your advisor/broker for further information or details.

1. I, ______________________, am a licensed insurance agent in the province of ______________________.
2. This transaction is between you and WAWANESA LIFE.
3. In soliciting this transaction, I am representing WAWANESA LIFE and ______________________ (Name of Agency).
4. In the past 12 calendar months, the majority of the insurance or financial products that I have sold were issued by the following companies: ____.
5. I am committed to selling on the basis of needs.
6. Upon completion of this transaction, I will receive compensation from WAWANESA LIFE and may receive additional compensation in the form of bonuses, conference programs or other incentives.
7. The nature and extent of my relationship with WAWANESA LIFE is as an independent insurance agent.
8. I and WAWANESA LIFE are prohibited from requiring you to transact additional business with WAWANESA LIFE or any other person or corporation as a condition of this transaction.

   I declare the following conflicts of interest, if any: ______________________

DATE ______________________ SIGNATURE OF ADVISOR/BROKER ______________________

NOTICES & DISCLOSURE STATEMENTS

These notices and disclosures must be given to the Proposed Life/Lives Insured.

NOTICE OF MEDICAL INFORMATION BUREAU (MIB)

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, ON Canada M5G 1R7, telephone number (416) 597-0590.

We, or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF CONSENT TO OBTAIN & RELEASE MEDICAL/UNDERWRITING INFORMATION

In the processing of the application for insurance, The Wawanesa Life Insurance Company may obtain records, investigative or medical reports containing personal information about the individuals proposed for insurance.

As part of the underwriting process, the Medical Director of Wawanesa may need to release medically related information obtained during the underwriting process to your personal physician or other medical practitioner. We may also need to disclose information regarding the underwriting factors to your Wawanesa Life advisor/broker.

NOTICE OF CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

We collect, use and disclose your personal information in order to administer the products and services you have requested. Personal Information is collected for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; receiving payments of insurance premiums and policy loan repayments; depositing funds into your account; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law.

In order to provide service to you in the future and provide you with the benefits included in the policy, Wawanesa Life may need to collect, use and disclose additional personal information about you. We may not require you to provide consent at that time.

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.

CHANGE IN INSURABILITY

If there is a change in insurability of any individual proposed for insurance subsequent to the completion of the application and before the policy is mailed to the Policyowner, The Wawanesa Life Insurance Company must be notified in order to properly evaluate the risk. If the change in insurability is not communicated and the Company is not given a chance to assess the risk, any policy issued pursuant to this application shall not take effect.

Change in insurability includes: a change in occupation or lifestyle that would increase risks to the insured's life or health; any change that would cause the insured to answer health or lifestyle questions differently than when they applied for the insurance; the diagnosis or identification of any health-related condition; and any pending or completed medical tests or exams.

THE WAWANESA LIFE INSURANCE COMPANY
400-200 MAIN STREET, WINNIPEG, MB R3C 1A8
PHONE 1-204-985-3940
TOLL FREE 1-800-263-6785
FAX 1-888-985-3872