Print Reset

Application for REINSTATEMENT and/or CHANGE

Wawanesa Life

Print Reset

APPLICATION FOR REINSTATEMENT AND/OR CHANGE

A. POLICY IDENTIFICATION – complete in all cases (print)

POLICY NO.

1. ☐ Life Insured ☐ Policy Owner

Name: Last | First | Middle

Address

Phone Numbers: Home | Business

Occupation | Employer's Name

2. ☐ Second Insured ☐ Policy Owner ☐ Joint Policy Owner

Name: Last | First | Middle

Business Name

Address

Phone Numbers: Home | Business

Occupation | Employer's Name

DECLARATION OF TAX RESIDENCE (only required for Conversion to permanent cash value product plan change)

3. (a) U.S. CITIZEN OR RESIDENT

Individual(s):	Policy Owner	Joint Policy Owner (if applicable)
Are you a U.S. citizen or a U.S. resident for U.S. tax purposes?	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes', provide your U.S. Taxpayer Identification Number (TIN):		

Entities:

Please complete the *Declaration of Tax Residence for Entities* form available on the Broker Forms page of our website.

(b) RESIDENT OF A COUNTRY OTHER THAN CANADA OR THE U.S.

Individual(s):	Policy Owner	Joint Policy Owner (if applicable)
Are you a tax resident of a jurisdiction other than Canada or the U.S.?	Yes ☐ No ☐	Yes ☐ No ☐

If 'Yes', give your jurisdictions of tax residence and taxpayer identification numbers (TIN).

If you do not have a TIN for a specific jurisdiction, give the reason using one of these choices:

Reason 1: I will apply or have applied for a TIN but have not yet received it.

Reason 2: My jurisdiction of tax residence does not issue TINs to its residents.

Reason 3: Other reason.

	Jurisdiction of tax residence	**Taxpayer identification number**	**If you do not have a TIN, choose reason 1, 2 or 3**
Policy Owner			
Joint Policy Owner			

If reason 3 is selected, please specify:

Entities:

Please complete the *Declaration of Tax Residence for Entities* form available on the Broker Forms page of our website.

Canadian financial institutions are required under Part XVIII and Part XIX of the *Income Tax Act* to collect the information you provide on this form to determine if we have to report your financial account to the Canada Revenue Agency (CRA). The CRA may share this information with the government of a foreign jurisdiction that a person identified on this form is a resident of for tax purposes. In the case of the United States, the CRA may also share the information with the U.S. government if the person is a U.S. citizen.

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B. DESCRIPTION (check all that apply) EFFECTIVE DATE OF CHANGE _____

☐ Reinstatement

Note: *To reinstate Instant Issue policy, Final Expense policy or Quick Issue Critical Illness policy, complete an application for that plan.*

- If within 180 days of first overdue premium, complete Quick Application for Reinstatement.
- If past 180 days of first overdue premium:
  - Complete Sections C, D, G and H.
  - For premiums paid via pre-authorized debit, also complete Section F.
  - Order age and volume underwriting requirements.

☐ Full Conversion or

☐ Full Exchange

Note: *Term exchange is only available within 5 years from the original issue date.*

New Plan: _____

- Complete Sections G and H.
- If premiums paid via pre-authorized debit, also complete Section F.
- If conversion, also complete Declaration of Tax Residence on Page 1.

Reissue Second Life Rider at current rates? ☐ Yes ☐ No

If Yes, please complete either the Full Application for Life Insurance or the Quick Life Application.

☐ Partial Conversion and/or

☐ Partial Exchange

Note: *Term exchange is only available within 5 years from the original issue date.*

New Plan: _____ Amount to be converted: $_____

New Plan: _____ Amount to be exchanged: $_____

- If conversion, also complete Declaration of Tax Residence on Page 1.

Balance:

☐ left at original rates? (*new band rate may apply)*

- Complete Sections G and H.
- If premiums paid via pre-authorized debit, also complete Section F.

or ☐ reissued as Term Rider?

- Complete either the Full Application for Life Insurance or the Quick Life Application.
- If premiums paid via pre-authorized debit, also complete Section F.

or ☐ cancelled?

☐ Critical Illness Plan Change

Note: *Critical Illness plan change is only available on 10-Year Term to Age 75 plans issued May 2002 or later.*

New Plan: _____ Amount: $_____

Balance:

☐ cancelled?

- Complete Sections G and H
- If premiums paid via pre-authorized debit, also complete Section F.
- Complete Declaration of Tax Residence on Page 1.

☐ Add Rider(s)/Benefit(s)

☐ Accidental Death or Disability Waiver

- Complete Sections C, D, G and H
- If premium paid via pre-authorized debit, also complete Section F.

☐ Child Protection Rider Volume: $_____

- Complete Sections C on the Life Insured
- Complete Sections C (questions 1, 2 & 3) and D on the child
- Complete Sections G and H
- If premium paid via pre-authorized debit, also complete Section F.

Note: Term Riders, Second Life Riders, and Joint Life Riders cannot be added using the Application for Reinstatement and/or Change. Please complete either the Full Application for Life Insurance or the Quick Life Application.

☐ Delete Rider(s)/Benefit(s)

Describe:

- Complete Sections G and H.

☐ Apply for Non-Smoker Rates

- Complete Sections C, G and H.
- If total coverage is $250,000 or more, a Urinalysis is required.

Note: Insured must not have used tobacco products in the previous 12 months *(including cigarettes, cigarillos, colts, cigars, pipes, chewing tobacco, snuff, e-cigarettes, nicotine gum or patches, or any form of nicotine substitute)* and must not have had any significant changes in insurability.

☐ Reconsider Rating

Describe:

- Complete Sections C, D, G and H.

☐ Other

Describe:

C. PERSONAL INFORMATION

1. For all individuals to be insured, show total life and critical illness insurance in force with this and other companies:

Name of Insured	Name of Company	Issue Year	Purpose of Insurance	Amount	AD Amount

2. NAME	D.O.B	BIRTHPLACE (only for CPR)	HEIGHT	WEIGHT	FULL NAME & ADDRESS OF PERSONAL PHYSICIAN	DATE & REASON LAST CONSULTED

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FOR ALL QUESTIONS ANSWERED 'YES', PROVIDE DETAILS IN QUESTION 12.	Life Insured YES	Life Insured NO	Other Life YES	Other Life NO
3. Has any individual to be insured:				
(a) Applied for any life, disability or critical illness insurance within the last 12 months, or is any other application pending or contemplated?	☐	☐	☐	☐
(b) Ever had any insurance company rate, decline, modify or postpone any application for or reinstatement of life, disability or critical illness insurance?	☐	☐	☐	☐
4. Has any individual to be insured:				
(a) Any intention of changing duties or occupation? If "Yes", provide details of new duties/occupation in question 12.	☐	☐	☐	☐
(b) Any plans to change country of residence or to travel outside of North America within the next 24 months? If so, please indicate location, purpose and intended length of stay.	☐	☐	☐	☐
(c) Flown within the last two years, or any intention of flying, other than as a passenger on commercially scheduled airlines? If 'YES', complete Aviation Questionnaire.	☐	☐	☐	☐
(d) Within the last two years, participated in any hazardous activities such as motor vehicle racing, parachute jumping, scuba diving, hang gliding, mountain/rock climbing, or is such activity contemplated? If 'YES', complete appropriate questionnaire.	☐	☐	☐	☐
5. Has any individual to be insured used any tobacco or nicotine products including cigarettes, cigarillos, colts, cigars, pipes, chewing tobacco, snuff, e-cigarettes, nicotine gum or patches, or any form of nicotine substitute? If 'YES', which one of the following applies:	☐	☐	☐	☐

LIFE INSURED	OTHER LIFE
☐ currently smoke daily less than 20 a day	☐ currently smoke daily less than 20 a day
☐ currently smoke daily more than 20 a day	☐ currently smoke daily more than 20 a day
☐ currently smoke occasionally (weekly, monthly, rare)	☐ currently smoke occasionally (weekly, monthly, rare)
☐ quit less than a year ago	☐ quit less than a year ago
☐ has not smoked/used the above products in the last 12 months	☐ has not smoked/used the above products in the last 12 months

If 'YES', how much?

TYPE	AMOUNT

	Life Insured YES	Life Insured NO	Other Life YES	Other Life NO
In the last 12 months?	☐	☐	☐	☐
In the last 2 years?	☐	☐	☐	☐
In the last 5 years?	☐	☐	☐	☐
Are you a former smoker who has not smoked/used the above products in the last 12 months? If 'Yes', please provide the reason for quitting and if you have been advised to quit by your doctor in question 12.	☐	☐	☐	☐
6. (a) Does any individual to be insured presently consume alcoholic beverages? If 'YES', please complete the following:	☐	☐	☐	☐

	BEER	WINE	LIQUOR	Check one: DAILY/WEEKLY/MONTHLY
QUANTITY:				☐ ☐ ☐

(b) Did you ever drink more than you do at the present? If "Yes", indicate the time frame, the amount and the reason for quitting or reducing your consumption in question 12.

7. Is any individual to be insured now using or has ever used the following drugs: Heroin, morphine, Demerol, methadone, Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital, hashish, cannabis, Benzadrine, Dexedrine, Methedrine, Cocaine, LSD, DMT, Mescaline, Peyote, Psilocybin, Anabolic Steroids?	☐	☐	☐	☐

If 'YES', please give details:

TYPE	QUANTITY & METHOD OF CONSUMPTION	FREQUENCY OF USE	DATES (from – to)

8. (a) Has any individual to be insured ever received treatment or been advised to seek treatment or medical advice because of alcohol or drug usage? If 'YES', provide date, name and address of any doctor, hospital or treatment center in question 12.	☐	☐	☐	☐
(b) Please add any additional information which you feel is important in question 12.				
9. Has any individual to be insured ever been convicted of a criminal offense or are any charges pending?	☐	☐	☐	☐

10. Driving History - Has any individual had:		
(a) more than **2** driving violations in the past **3 years**? If 'YES', please provide details including dates and types of violations in questions 12.	☐ ☐	☐ ☐
(b) a license suspension, DUI (driving under the influence) or reckless driving violations in the past **5 years?** If 'YES', please provide details including dates and types of ALL violations in question 12.	☐ ☐	☐ ☐
(c) more than one DUI (driving under the influence) conviction in the past 20 years? If 'YES', please provide details including dates and types of ALL violations in question 12.	☐ ☐	☐ ☐
(d) Do you have a valid Driver's License? If 'NO', provide details in question 12.	☐ ☐	☐ ☐
(e) Does individual to be insured have a valid Driver's License? If 'NO', provide details in question 12. If 'YES' provide: Life Insured: Doc. # _____ Jurisdiction_____ 2nd Life: Doc. # _____ Jurisdiction_____	☐ ☐	☐ ☐
11. Since the policy was originally applied for, has any individual to be insured:		
(a) had any illness, disease, operation or injury?	☐ ☐	☐ ☐
(b) consulted or been attended by a physician or other practitioner?	☐ ☐	☐ ☐
(c) have any reason to believe he/she is not in good health?	☐ ☐	☐ ☐

12. **USE THE FOLLOWING SECTION FOR DETAILS TO 'YES' ANSWERS IN SECTION C.**

Question #	Name of Insured	Details

D. MEDICAL INFORMATION – To be answered by each individual to be covered.

FOR ALL QUESTIONS ANSWERED 'YES', CIRCLE THE APPROPRIATE DISORDER AND PROVIDE DETAILS IN QUESTION 18.

13. (a) Have any of your biological parents, brothers or sisters, whether living or deceased, had any of the following?

- heart disease
- stroke
- cancer or any other tumor
- diabetes
- polycystic, or other kidney disease
- Huntington's Chorea
- motor neuron disease (including ALS/Lou Gehrig's Disease)
- Alzheimer's Disease
- Parkinson's Disease or
- any other hereditary disease

LIFE INSURED YES	LIFE INSURED NO	OTHER LIFE YES	OTHER LIFE NO
☐	☐	☐	☐

(b) **Please complete the following chart for ALL family members:**

Life Insured	DISEASE	AGE AT DIAGNOSIS	ACTUAL AGE, if living	CONDITION, if alive	AGE AT DEATH	CAUSE OF DEATH
FATHER						
MOTHER						
BROTHER (1)						
BROTHER (2)						
SISTER (1)						
SISTER (2)						

Other Life	DISEASE	AGE AT DIAGNOSIS	ACTUAL AGE, if living	CONDITION, if alive	AGE AT DEATH	CAUSE OF DEATH
FATHER						
MOTHER						
BROTHER (1)						
BROTHER (2)						
SISTER (1)						
SISTER (2)						

FOR ALL QUESTIONS ANSWERED 'YES', CIRCLE THE APPROPRIATE DISORDER AND PROVIDE DETAILS IN QUESTION 18.

14. Has the individual to be insured ever been treated for, been advised to seek advice or treatment for or had any known indication of, or any disorder of:	LIFE INSURED YES	LIFE INSURED NO	OTHER LIFE YES	OTHER LIFE NO
a) **THE EARS, EYES, NOSE, THROAT, LUNGS** including: ▪ sleep apnea ▪ persistent cough ▪ COPD ▪ sarcoidosis ▪ coughing up blood ▪ optic neuritis ▪ cystic fibrosis ▪ asthma ▪ any other eye, ear, nose, throat, or lung disorder ▪ shortness of breath ▪ bronchitis If 'YES' to bronchitis or asthma, please complete Bronchitis or Asthma Questionnaire.	☐	☐	☐	☐
(b) **THE HEART, ARTERIES OR OTHER PARTS OF THE CARDIOVASCULAR SYSTEM** including: ▪ angina ▪ high blood pressure ▪ peripheral vascular disease ▪ chest pain ▪ rheumatic fever ▪ abnormal EKG ▪ elevated cholesterol ▪ heart murmur ▪ any other disease or disorder of the heart or blood vessels ▪ palpitation ▪ heart attack ▪ irregular pulse ▪ bypass or angioplasty ▪ aneurysm ▪ pacemaker	☐	☐	☐	☐
(c) **THE ABDOMINAL ORGANS** including: ▪ ulcer ▪ hepatitis ▪ pancreatitis ▪ hernia ▪ jaundice ▪ colon polyps ▪ ulcerative colitis ▪ liver disease ▪ any other disease or disorder of the bowel, stomach, pancreas or liver ▪ rectal bleeding or blood in stool ▪ cirrhosis ▪ Crohn's disease ▪ chronic diarrhea	☐	☐	☐	☐
(d) **THE KIDNEYS, BLADDER and REPRODUCTIVE ORGANS** including: ▪ nephritis ▪ abnormal PAP ▪ blood, pus, sugar or protein in urine ▪ elevated PSA (prostate specific antigen) ▪ kidney stones ▪ any other disease or disorder of kidneys, bladder or reproductive organs ▪ breast disorder or unusual discharge ▪ abnormal mammogram or breast ultrasound	☐	☐	☐	☐
(e) **THE BRAIN AND NERVOUS SYSTEM** including: ▪ epilepsy ▪ impairment of balance ▪ motor neuron disease (including ALS/Lou Gehrig's disease) ▪ seizures ▪ memory impairment ▪ coma ▪ stroke ▪ cognitive impairment ▪ head injury ▪ transient ischemic attack (TIA) ▪ fainting spells ▪ persistent headaches ▪ multiple sclerosis ▪ paralysis ▪ any other disease of the brain or nervous system ▪ numbness or tingling of limbs ▪ dementia ▪ impairment of speech ▪ Alzheimer's disease ▪ Parkinson's disease	☐	☐	☐	☐
(f) **MENTAL HEALTH** including: ▪ depression ▪ developmental delay or disability ▪ anxiety ▪ eating disorder ▪ panic attacks ▪ chronic fatigue ▪ PTSD ▪ ADD or ADHD ▪ bi-polar disorder ▪ attempted suicide or suicidal thoughts ▪ schizophrenia ▪ any other emotional or psychiatric disorder	☐	☐	☐	☐
(g) **THE BLOOD, GLANDS and ENDOCRINE SYSTEM** including: ▪ anemia ▪ leukemia ▪ unexplained infections ▪ bleeding disorder ▪ night sweats ▪ any other endocrine or blood disease or disorder ▪ blood clot ▪ enlargement of lymph nodes (glands) ▪ diabetes	☐	☐	☐	☐
(h) **THE MUSCULO-SKELETAL SYSTEM** including: ▪ arthritis ▪ amputation ▪ any other disorder of the muscles, bones or joints ▪ rheumatoid arthritis ▪ chronic pain ▪ lupus ▪ muscular dystrophy	☐	☐	☐	☐
(i) **THE IMMUNE SYSTEM** including: ▪ acquired immune deficiency syndrome (AIDS) ▪ AIDS related complex (A.R.C.) ▪ any other immunological disorder ▪ positive HIV test	☐	☐	☐	☐
(j) **CANCER, GROWTH and SKIN DISORDERS** including: ▪ cancer ▪ abnormal biopsy or pathology result ▪ any other growth or malignancy ▪ cyst, tumor, lump, polyp or other growth ▪ mole or unusual skin lesion(s)	☐	☐	☐	☐

D. MEDICAL INFORMATION (continued)

15. Other than as disclosed in the answers above, has any individual to be insured:				
(a) Consulted a doctor or medical practitioner within the last 5 years?	☐	☐	☐	☐
(b) Had an EKG, Blood Tests or other diagnostic test within the last 5 years?	☐	☐	☐	☐
(c) Been a patient in a hospital or other medical facility within the last 5 years?	☐	☐	☐	☐
(d) Currently awaiting test results or been advised to have any diagnostic test, hospitalization or surgery which **has not been completed**?	☐	☐	☐	☐
(e) Ever been tested for exposure to the AIDS virus?	☐	☐	☐	☐
(f) Lost more than 10 pounds (4.53 kg) within the last year?	☐	☐	☐	☐
(g) Requested or received a pension, benefits, disability payment or settlement because of an injury or illness?	☐	☐	☐	☐
(h) Had any health symptoms or complaints for which a physician has **NOT been consulted or treatment received**?	☐	☐	☐	☐
16. (a) Is any individual to be insured currently under any treatment or medication?	☐	☐	☐	☐
(b) Do you have any reason to believe you are not in good health?	☐	☐	☐	☐
For Females Only:				
(c) Are you currently pregnant? If so, please provide your due date: _____	☐	☐	☐	☐
(d) Is it a normal pregnancy to date?	☐	☐	☐	☐
17. Has there been any change in name in the last 5 years (marriage, etc.)? If 'YES', please provide previous name(s) in question 18.	☐	☐	☐	☐

18. USE THE FOLLOWING SECTION FOR DETAILS TO 'YES' ANSWERS IN SECTION D.

QUESTION NUMBER	PROPOSED INSURED	DETAILS AS TO DIAGNOSIS, DURATION AND RESULTS	DATE	NAME AND ADDRESS OF PHYSICIAN AND/OR HOSPITAL

E. UNIVERSAL LIFE QUESTIONNAIRE (For changes on existing Universal Life plans)

Section A – Basic Information

AMOUNT OF INSURANCE:

UL SCHEDULED PREMIUM $ _____ $ _____

(Premiums for riders and benefits should be listed on page 10)

Section B – Universal Life Illustration Assumptions – All factors are chosen by the applicant.

How the Wawanesa Life Universal Life policy works:

All premiums received, less any Premium Taxes, are deposited to the Daily Interest Account. An amount representing the Monthly Cost of Insurance and Monthly Administration Fee is withdrawn from the Daily Interest Account every month. The balance may be directed to any of the following Savings Options at your discretion:

UNIVERSAL LIFE – SAVINGS OPTIONS		ALLOCATION OF SCHEDULED PREMIUMS*	ASSUMED INVESTMENT RATES**
GUARANTEED INTEREST ACCOUNTS	DAILY INTEREST ACCOUNT		
	INVESTMENT ACCOUNT ACCUMULATOR: When the balance reaches $250.00, an Investment Account for a term of _____ years will be created.		
INDEX-LINKED OPTIONS	CANADIAN EQUITY INDEX-LINKED ACCOUNT		
	U.S. EQUITY INDEX-LINKED ACCOUNT		
	INTERNATIONAL EQUITY INDEX-LINKED ACCOUNT		
	CANADIAN BOND INDEX-LINKED ACCOUNT		
* For any option chosen, the minimum percentage is 5%. ** As chosen by the applicant for illustration purposes only.	**TOTAL**	**100%**	**NET ILLUSTRATION INTEREST RATE** _____**%**

F. PAYMENT INFORMATION (Select one)

☐ Monthly Pre-Authorized Debit (PAD)* ☐ Semi-Annual Billing
☐ Semi-Annual PAD* ☐ Annual Billing
☐ Annual PAD*
*** Complete PAD section below.**

Total Modal Premium $ _____
plus sales tax, if applicable

Amount paid with this application $ _____

PRE-AUTHORIZED DEBIT (PAD)

☐ Use my current Wawanesa Life PAD under Policy # _____ or PAD # _____ or:

☐ Establish a new PAD and use:

☐ Details from initial premium cheque ☐ Details from VOID cheque (attached) ☐ Information provided below:

Account Owner Name(s) _____ Telephone _____

Account Owner Address (if different from policy owner) _____

Transit # _____ Fin. Inst. # _____ Account # _____

Branch Address _____ Withdrawal date: ☐ Policy date or ☐ ____ (1st – 28th)

☐ Draw premium upon approval.

G. AGREEMENT AND DECLARATION / AUTHORIZATION AND SIGNATURES

Each of the undersigned insureds and/or policy owners agree that:

1. All statements, agreements, representations and answers made in this Application, and any additional declarations or answers which may be made in any personal declaration required in connection with this Application, together with all prior applications, shall be consideration for the basis of the reinstatement and/or changed policy(ies) hereby requested.
2. The answers to the statements and questions are complete, true and correctly recorded.
3. In order to effect the change the Company shall have the right either (a) to cancel the present policy and make another policy containing current terms corresponding to the terms of the changed policy, or (b) to amend the present policy.
4. Except as changed by this Application, any indebtedness under the policy and the rights of any beneficiary, assignee or other person having an interest in the policy shall remain as unchanged.
5. Delivery to and acceptance by the policy owner of any policy issued in consequence of this Application will ratify any amendments to the change of policy made by the Company.
6. The reinstatement and/or change shall not take effect until: (a) approved by the authorized officers of the Company, (b) all premiums and fees required have been paid, and (c) the policy is delivered, no change having taken place in the insurability of the Life Insured, Second Life Insured or Insured Children subsequent to the completion of this Application.
7. If, within two years from the date of approval of the reinstatement and/or change, the Life Insured or any other individuals proposed for coverage dies by suicide, whether sane or insane, or if any information submitted in support of this Application is proved to be materially incomplete or untrue, the reinstatement and/or change will be void.

AUTHORIZATION: THE FOLLOWING AUTHORIZATION IS VALID FOR EACH INDIVIDUAL FOR WHOM EVIDENCE OF INSURABILITY IS REQUIRED.

I acknowledge having received the notices regarding Medical Information Bureau Inc. (MIB, Inc.) and Investigative Reports, and consent to such reports being obtained by Wawanesa Life. I authorize Wawanesa Life, or its reinsurers, to make a brief report of my personal health information to The Medical Information Bureau Inc. (MIB, Inc.).

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau Inc. (MIB, Inc.), Motor Vehicle Department concerning driver 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/our personal physician or other medical practitioner.

PRE-AUTHORIZED DEBIT (PAD) AUTHORIZATION (if applicable – please complete Section F on page 9)

I request and authorize Wawanesa Life to make withdrawals from the account designated on page 9 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.

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.

POLICY BENEFITS DISCLOSURE STATEMENTS – UNIVERSAL LIFE PLANS ONLY

I acknowledge and understand that:

1. An illustration of the product applied for has been presented to me for review.
2. Investment returns for the purposes of the illustration have been chosen by me and are NOT GUARANTEED.
3. The account values and cash surrender values illustrated will change subject to fluctuation in future investment values.

Variations in these factors will also impact any illustration in which it is projected that premiums may be discontinued at some future time.

G. AGREEMENT AND DECLARATION / AUTHORIZATION AND SIGNATURES (Continued)

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; withdrawing premiums from and depositing funds into my account (applicable if PAD Agreement is signed); 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 have read and understood that Wawanesa Life may share my personal information with the required people, organizations and service providers as described in the Notice of Consent & Disclosure Regarding Personal Information on Customer Copy, who may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions.

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.

I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to provide me with the product or service being applied for or having to terminate the policy.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from the Wawanesa Life Executive Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

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 complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance: Senior Vice President, Chief Legal Officer & Corporate Secretary, The Wawanesa Life Insurance Company, 900-191 Broadway, Winnipeg, Manitoba R3C 3P1.

I confirm that I have read, understood and accepted the terms and conditions of the agreements, declarations and authorizations contained in this application. I further confirm that all of my answers to the declarations are truthful and complete to the best of my information, knowledge and belief. A photocopy or an electronic reproduction of this document will be as valid as the original.

Signed at _____ in the province of _____. Date _____

Life Insured, or parent if Life Insured is under age 16 **(please print)**	**Life Insured**, or parent if Life Insured is under age 16 (**signature)**	**Child under Child Protection Rider**, if age 16 or older **(signature)**
Second /Joint Life Insured (please print)	**Second/Joint Life Insured (signature)**	**Witness (signature)**
Policy Owner, if other than Life Insured (please print)	**Policy Owner, if other than Life Insured (signature)**	**PAD Account Owner (signature)**

H. STATEMENT BY INDEPENDENT INSURANCE BROKER

PREMIUM CALCULATIONS

BASIC PLAN $_____

TERM RIDER 1 $_____

TERM RIDER 2 $_____

TERM RIDER 3 $_____

TERM RIDER 4 $_____

SECOND/JOINT LIFE INSURED RIDER 1 $_____

SECOND/JOINT LIFE INSURED RIDER 2 $_____

SECOND/JOINT LIFE INSURED RIDER 3 $_____

SECOND/JOINT LIFE INSURED RIDER 4 $_____

CHILD PROTECTION RIDER $_____

DISABILITY WAIVER $_____

ACCIDENTAL DEATH $_____

OTHER: _____ $_____

POLICY FEE $_____

TOTAL PREMIUM $_____

SALES TAX (if applicable) $_____

TOTAL AMOUNT $_____

Modal Premium: ☐ Monthly $_____

☐ S.A. $_____

☐ Annual $_____

Amount paid with Application $_____

1. Does any proposed insured have any obvious physical impairment or do you know anything about the insured that might affect the risk?
   ☐ YES ☐ NO

2. If insurance is applied for on a minor child:
   Have you seen the child? ☐ YES ☐ NO
   Does the child appear healthy? ☐ YES ☐ NO
   Do you know anything about the child that might affect the risk? ☐ YES ☐ NO
   Does the child reside with the parent/guardian? ☐ YES ☐ NO

3. What evidence is being submitted or arranged? ☐ Paramed ☐ Xray ☐ Blood ☐ Urinalysis ☐ EKG ☐ HOS
   Name of paramed facility or examiner: _____
   MVR to be ordered by (check one, if applicable): ☐ Branch Office ☐ Executive Office

4. Mail policy to: ☐ Policy Owner (direct delivery) or ☐ Independent Insurance Broker (personal delivery)
   If no preference is indicated, policy will be mailed directly to policy owner.

5. Details of 'YES' answers and additional comments ('NO' answers to question 2).

INDEPENDENT INSURANCE BROKER'S DECLARATION

I declare that I have asked and fully recorded the answers of all lives proposed to all questions on this Application, and that I know of nothing that is material to their insurability that has not been recorded herein. I am aware of and in compliance with the Company's Sales Code of Ethics.

Confirming Independent Insurance Broker Disclosure (purchase of insurance only)

I have provided the applicant(s) with written materials advising: about the company(s) I currently represent; that I receive compensation (such as commissions or a salary) for the sale of life and health insurance products; that I may receive additional compensation in the form of bonuses or other incentives; and of any conflicts of interest I may have with respect to this transaction.

_____ _____

SELLING BROKER (please print) SELLING BROKER (signature)

ALLOCATION OF THIS SALE

		FIRST YEAR	RENEWAL
_____ AGENT OF RECORD (please print)	_____ Broker Number	_____%	_____%
_____ SERVICING AGENT (please print)	_____ Broker Number	_____%	_____%
_____ OTHER (please print)	_____ Broker Number	_____% **100**	_____% **100**

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

APPLICATION FOR REINSTATEMENT AND/OR CHANGE

NOTICES & DISCLOSURE STATEMENTS
CUSTOMER COPIES

NOTICE OF MEDICAL INFORMATION BUREAU, INC. (MIB, Inc.)

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

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 330 University Avenue, Suite 501, Toronto, ON 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 INVESTIGATIVE REPORTS

In the processing of the application for reinstatement/change, The Wawanesa Life Insurance Company may obtain Motor Vehicle Driving abstract/records, a personal investigation or consumer reports containing personal information about the individuals proposed for insurance.

NOTICE OF CONSENT TO RELEASE MEDICAL/UNDERWRITING INFORMATION

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 independent insurance 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; withdrawing premiums from and depositing funds into your account (applicable if PAD Agreement is signed); detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law.

We may share your personal information with the following people, organizations and service providers: Wawanesa Life employees and independent insurance brokers who require this information to perform their jobs; third party providers who require this information to provide their services to you, which may include paramedical agencies, underwriters, claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies to allow them to evaluate and administer any insurance risk that the accept; the Medical Information Bureau Inc. (MIB, Inc.) as explained the notice provided; people to whom you have granted access; and people who are legally authorized to view your personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. Your information may be shared as required by the laws of those jurisdictions.

There are other situations where we may share aspects of your personal information with others, as described below:

- We may share medical information collected about you with your doctor.
- We may share your personal information with an organization or person from whom we are collecting information about you, but only as required to obtain the information needed.
- If laboratory tests performed on our behalf show that you have tested positive for infectious diseases such as HIV or hepatitis, we may report this information to the appropriate public health authorities, as required.

Because the medical information you include in this application becomes part of the printed contract, in the case of a corporate or joint policy, your medical information may be included in the policy contract issued to the policy owner(s) and any subsequent owners.

In order to provide services 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.

Any restriction or withdrawal of your consent may result in Wawanesa Life being unable to provide you with the product or service being applied for or having to terminate the policy.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from the Wawanesa Life Executive Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

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 complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance: Senior Vice President, Chief Legal Officer & Corporate Secretary, The Wawanesa Life Insurance Company, 900-191 Broadway, Winnipeg, Manitoba R3C 3P1.

NOTICE OF CONSENT REGARDING PRE-AUTHORIZED DEBIT (PAD) AUTHORIZATION (if applicable)

You request and authorize Wawanesa Life to make withdrawals from the account designated on page 8 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. You 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. You have certain recourse rights, provided under the personal PAD agreement, if any debit does not comply with the agreement. For example, you 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. You may provide written request to add/delete policies to the PAD agreement or change bank information without completing a new PAD agreement.
6. **You 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.**

POLICY BENEFITS DISCLOSURE STATEMENTS – UNIVERSAL LIFE PLANS ONLY

WAWANESA LIFE IS COMMITTED TO AN HONEST AND OPEN RELATIONSHIP WITH ITS CLIENTS. TO ACHIEVE THIS, WE ASK THAT YOU READ THE FOLLOWING DISCLOSURE STATEMENTS. THEY CONTAIN THE KEY ELEMENTS OF THE UNIVERSAL LIFE PLAN YOU HAVE CHOSEN AND OUR INDEPENDENT INSURANCE BROKER WANTS TO ENSURE THAT YOU HAVE A COMPLETE UNDERSTANDING OF YOUR PLAN.

You acknowledge and understand that:

1. An illustration of the product applied for has been presented to you for review.
2. Investment returns for the purposes of the illustration have been chosen by you and are NOT GUARANTEED.
3. The account values and cash surrender values illustrated will change subject to fluctuation in future investment returns.
4. Variations in these factors will also impact any illustration in which it is projected that premiums may be discontinued at some future time.

INDEPENDENT INSURANCE BROKER DISCLOSURE STATEMENT

INDEPENDENT INSURANCE BROKER DISCLOSURE STATEMENT

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

1. I, _____, am a licensed insurance broker 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 or other incentives.
7. The nature and extent of my relationship with WAWANESA LIFE is as an independent insurance broker.
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.
9. I declare the following conflicts of interest, if any:

   _____

_____ _____

DATE SIGNATURE OF INDEPENDENT INSURANCE BROKER

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