Independent Business Owner Application

Extended Health and Dental Insurance

PRINT IN INK, ALL QUESTIONS MUST BE COMPLETED
MAIL COMPLETED FORM TO WAWANESA LIFE

ELIGIBILITY

To apply for coverage, you must be:

- **active with the IBOBA**
- **resident of Canada and covered under provincial government health plan**
- **between the ages of 18 and 60**
- **coverage terminates at age 70**

Part A - Plan Choice

NEW APPLICANT:

Type of Coverage	Coverage Required			Effective Date Month	Day	Year	Waive Coverage (mark with X)
Extended Health (Including Travel)	☐ Single	☐ Couple*	☐ Family				☐
Dental	☐ Single	☐ Couple*	☐ Family				☐
Extended Health (including travel) and Dental	☐ Single	☐ Couple*	☐ Family				☐

NOTE: The same choice must be made for both Extended Health Care and Dental Insurance Prescription Drug coverage not available in Quebec

* One adult and one child qualify as a couple

Are you covered by a Provincial Health Care Plan? ☐ Yes ☐ No

Part B - General Information

Last Name ____ Legal First Name ____ Preferred First Name ____

Address ____

City ____ Province ____ Postal Code ____

Applicant's occupation____________________ Home telephone______________ Business Telephone ______________

Fax #______________ Social Insurance Number____________________ IBO # or Member # ____________________

E-Mail:__________________________________ IBO Level ____________________

Gender: ☐ Male ☐ Female Language: ☐ English ☐ French

Marital Status: ☐ Single ☐ Married ☐ Common-Law

Part C - Individuals To Be Covered

Applicant, Spouse and Dependent Children Information – Please provide us with the first name and initial of all family members to be covered, plus the last name of any dependents if different from the applicants.

Last Name	First Name & Initial(s)	Sex M/F	Birthdate Month	Day	Year	Height	Weight	Physician's Name
Applicant								
Spouse								
Child								
Child								

Part D – Coordination of Benefits Information

Does your spouse have other insurance coverage? ☐ Yes ☐ No If yes, please provide details

Name of spouse's insurance carrier: ______________________________

Are you and your child(ren) covered on this plan? ☐ Yes ☐ No

Does this plan cover Health? ☐ Yes ☐ No Dental ? ☐ Yes ☐ No

By signing this enrollment form or by providing my personal information, I agree the information is complete and accurate to the best of my knowledge. I am authorized to release information concerning my spouse and my dependents for the purposes of determining their eligibility for benefits. If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits

Date:______________________ Signature of Subscriber ______________________________

Part E - Other Individual Coverage

Are you currently covered by another Individual Health Plan? ☐ Yes ☐ No

If yes, original effective date:______________________Name of insurance company: ______________________

When does/did your existing Individual Health & Dental Benefits end? ______________________

Are you covered, or were you covered by a Wawanesa Life Group Plan within the last 60 days?

☐ Yes ☐ No

If yes, when does/did your Wawanesa Life Group Benefits end? ______________________

Group Number:______________________ Company Name:______________________

Part F - Statement of Health for Applicant, Spouse and Dependent Children

IF APPLYING FOR DENTAL COVERAGE ONLY, ANSWER QUESTIONS 6 & 7 ONLY

1. Have you, or any listed dependent, been hospitalized in the last two years?

   Applicant: ☐ Yes ☐ No Spouse/Dependent Children ☐ Yes ☐ No

2. Do you, or any listed dependent, expect to be hospitalized in the next three months?

   Applicant: ☐ Yes ☐ No Spouse/Dependent Children ☐ Yes ☐ No

3. Have you, or any listed dependent, EVER been treated for, consulted or received advice from a physician or specialist about any of the following conditions ☐ Yes ☐ No (one must be checked off)
   If 'YES', please check the appropriate box below as it applies:

   ☐ Mental or brain disorder, Alzheimer, Parkinson's, memory loss or dementia, seizures or paralysis
   ☐ Circulatory, heart or vascular disease, high blood pressure, angina, stroke or elevated cholesterol
   ☐ Aids, ARC (Aids Related Complex) or other immunological disorder
   ☐ Stomach, intestinal, liver, kidney or bladder disorder
   ☐ Arthritis/Rheumatism
   ☐ Back or joint disorder
   ☐ Emphysema or asthma
   ☐ Infertility/reproductive disorder
   ☐ Alcoholism or drug abuse
   ☐ Headaches/migraines
   ☐ Diabetes, colitis or Crohn's
   ☐ Skin disorder
   ☐ Cancer, tumor or leukemia

   If you answered 'YES' to question 1 or 2, or checked any of the boxes in question 3, please give details below:

First Name Only	Condition	Date first treated	Duration of Treatment	Type of Treatment	Results or Recovery

4. Have you, or any listed dependent, been treated for or referred to a specialist or to another physician for a second opinion *for any other condition not listed in Question 3?* ☐ Yes ☐ No
   If 'YES' please state condition: ______________________________

5. Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories?

   Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No Child(ren): ☐ Yes ☐ No

   If yes, please complete this section:

Name of person to be insured	Condition	Medication, Treatment and/or device	Monthly Cost	Strength	Daily Dosage	Length of Time

6. Have you or any listed dependent, visited your dentist on an annual basis over the last three (3) years?

   ☐ Yes ☐ No

7. Do you, or any listed dependent, plan to visit your dentist within the next two (2) months? ☐ Yes ☐ No

   If yes, please indicate dental work to be done _

   ____

   NOTE: If the **proposed dental work** is expected **to exceed $300.00**, a **detailed treatment plan** is required from your dentist **before your treatment begins**.

Part G – Personal Information Consents

The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among the Wawanesa Life Insurance Company, their agents, affiliates, partners subsidiaries, reinsurers, rating agencies, and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

Part H - Authorization to be signed by all applicants

Note: The information provided on this form is confidential. Claims are adjudicated by Green Shield Canada

The statements contained herein are true and complete and form the basis for any coverage approved. **Failure to disclose or falsifying information regarding my health and/or that of my spouse and/or dependents, could result in a denial of a claim and the cancellation of my coverage.** I/We understand that the coverage shall not become effective until approved by The Wawanesa Life Insurance Company. I/We authorize any physician, dentist, medical practitioner, hospital, clinic or other medical related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, to give The Wawanesa Life Insurance Company any such information as it pertains to this insurance.

A reproduction of this consent and authorization shall be as valid as the original.

Signature of Applicant:____Date: ______________________

Signature of Spouse:____Date: ______________________

Mailing Instructions:

- Do not send money with this application
- Complete Part H and attach void cheque if Payment Option 1 is selected
- Coverage is not approved until Wawanesa Life notifies in writing
- Mail completed form to Wawanesa Life

PAYMENT OPTION FORM

INSURED: ______________________ **POLICY NUMBER:** ______________________

Please choose one of the following two payment options.

❐ OPTION 1 – PRE-AUTHORIZED PAYMENT PLAN – *Attach Cheque Marked 'VOID'*

Name of Bank Account Holder: ______________________

❐ OPTION 2 – CREDIT CARD – *Only available on select products*

The Wawanesa Life Insurance Company is authorized to charge my Credit Card. I agree to furnish The Wawanesa Life Insurance Company with the updated Credit Card Expiry date as required. This authorization extends to any replacement cards I may receive and will remain in effect until I cancel it.

Card Type: ☐ MASTERCARD ☐ VISA *Amex, Debit or Prepaid Cards are not accepted.*

Card Number: ______________________ Expiry Date: ______________________

Name as it appears on the Credit Card: ______________________

Cardholder Address: ______________________

City: ______________ Province: __________ Postal Code: __________ Telephone: ______________

AUTHORIZATION AND SIGNATURE

☐ Regular MONTHLY payments in the amount of $ ________ will be debited to my/our account or charged to the credit card on the ________ day of each month.

☐ Regular ANNUAL payment in the amount of $____________ will be debited to my/our account or charged to the credit card on ____________ (MM/DD) of each year.

I understand that premiums may increase by the amount required to keep my policy in effect as stated in my policy. I agree that this authorization in no way affects the terms or conditions of the policy.

The Wawanesa Life Insurance Company is authorized to draw cheques under its Pre-Authorized Payment Plan (PAPP) on the Account and Financial Institution designated by me. I further authorize such institution and any of its branches to deal with such transfers as though they were signed by me.

- 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.
- I also agree to furnish The Wawanesa Life Insurance Company with a voided blank cheque now and at any future time, as required, to assure the accurate imprinting of bank information on my Pre-Authorized transfers.
- I may revoke my authorization at any time, subject to providing notice of 10 days' notice. To obtain a sample cancellation form, or for more information on my right to cancel a PAPP Agreement, I may contact my financial institution or visit www.cdnpay.ca
- Every effort will be taken to meet the same date every month, however this date could change for a given month.
- Wawanesa Life is not required to provide notification before the initial premium is debited.
- I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAPP agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca

This authorization shall continue in force so long as said policy shall qualify for premium payments under this plan or until this authorization is revoked. Either party to this agreement may terminate this authorization by written notice mailed to the other party at his address of record.

Signature of Bank Account Holder / Credit Cardholder: ______________________ Dated: ______________ (MM/DD/YYYY)

Signature of Bank Account Holder / Credit Cardholder: ______________________ Dated: ______________ (MM/DD/YYYY)

PERSONAL INFORMATION CONSENT:
The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among The Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

THE WAWANESA LIFE INSURANCE COMPANY
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