Application for Reinstatement and/or Change

A. Policy Identification (complete in all cases - please print)

Policy Number: _____

1. ◯ **Life Insured** ◯ **Policy Owner**

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

Home Phone Number: _____ Business Phone Number: _____

Email: _____

Occupation: _____ Employer's Name: _____

2. ◯ **Policy Owner** ◯ **Joint Policy Owner**

Last Name: _____ First Name: _____ Middle Name: _____

Business Name: _____

Address: _____

Home Phone Number: _____ Business Phone Number: _____

Email: _____

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.

B. Description (check all that apply)

Effective Date of Change: _____

☐ **Reinstatement**

- 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, H and I.
  - For premiums paid via pre-authorized debit or credit card, also complete Section G.
  - Order age and volume underwriting requirements.

◯ **Full Conversion or** ◯ **Full Exchange**

New Plan: _____

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

Note: *Term exchange is only available within 7 years from the original issue date.*

◯ **Partial Conversion and/or** ◯ **Partial Exchange**

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 H and I.
- If premiums paid via pre-authorized debit or credit card, also complete Section G.

or ◯ cancelled?

Note: *Term exchange is only available within 7 years from the original issue date.*

☐ **Critical Illness Exchange Option**

New Plan: _____

◯ CI Term to age 75 ◯ CI Term 75 with Return of Premium on Expiry

Amount: _____

Include exisiting Disability Waiver of Premium Benefit in the new plan? ◯ Yes ◯ No

Balance:

◯ Cancelled?

- Complete Sections H and I.
- If premiums paid via pre-authorized debit or credit card, also complete Section G.

Note: *Critical Illness plan change is only available on 10-Year Term to Age 75 plans issued May 2002 or later. The exchange option can be exercised anytime pirior to the policy anniversary immediately following the insured person's 60th birthday.*

☐ **Add Rider(s)/Benefit(s)**

☐ Child Protection Rider Volume: _____

- Complete Sections E on the children
- Complete Sections H and I
- If premiums paid via pre-authorized debit or credit card, also complete Section G.

☐ Child Critical Illness Rider Volume: _____

- Complete Sections H and I
- If premiums paid via pre-authorized debit or credit card, also complete Section G.

☐ **Delete Rider(s)/Benefit(s)**

Describe: _____

Complete Sections H and I.

☐ **Apply for Non-Smoker Rates**

- Complete Sections C, H and I.
- 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.*

**Occasional Cigar Smokers will be granted Non-Tobacco user rates providing he/she: Does not smoke more than 12 large cigars a year, does not have any traces of nicotine in the urine when fluids are required and makes full disclosure of smoking activities on the application or teleinterview. This ruling does not apply to cigarettes, cigarillos, colts, pipes, chewing tobacco, snuff, e-cigarettes, vaporizers, nicotine gum or patches or any form of nicotine substitute.*

☐ **Reconsider Rating**

Describe: _____

Complete Sections C, D, H and I.

☐ **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

Name	D.O.B.	Birthplace (only for CPR)	Height	Weight	Full Name & Address of Personal Physician	Date & Reason Last Consulted

For all questions answered 'yes', provide details in question 12.

3. Has any individual to be insured:	Life Insured	Policy Owner
(a) Applied for any life, disability or critical illness insurance in the last 12 months, or is any other application pending or contemplated?	◯ Yes ◯ No	◯ Yes ◯ No
(b) Ever had any insurance company rate, decline, modify or postpone any application for or reinstatement of life, disability or critical illness insurance?	◯ Yes ◯ No	◯ Yes ◯ No

4. Has any individual to be insured:	Life Insured	Policy Owner
(a) Any intention of changing duties or occupation	◯ Yes ◯ No	◯ Yes ◯ No
(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.	◯ Yes ◯ No	◯ Yes ◯ No
(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.	◯ Yes ◯ No	◯ Yes ◯ No
(d) Within the last two years, participated in any adventurous activities (including but not limited to motor vehicle racing, parachute jumping, skydiving, scuba diving, hang gliding, mountain/rock climbing, backcountry snowmobiling, skiing/snowboarding, combat sports, or is such activity contemplated? If 'YES', complete appropriate questionnaire.	◯ Yes ◯ No	◯ Yes ◯ No

5. In the last 12 months, have you used any tobacco or nicotine products including cigarettes, cigarillos, colts, cigars, pipes, chewing tobacco, snuff, e-cigarettes, vaporizers, nicotine gum or patches, or any form of nicotine substitute?	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

If yes, please choose the response that best describes your smoking habits:

◯ I am a daily smoker ◯ I smoke occasionally ◯ I quit less than a year ago

In the last 12 months, have you ONLY smoked LARGE cigars?

◯ No ◯ Yes, MORE than 12 large cigars ◯ Yes, 12 or LESS large cigars

6. (a) Does any individual to be insured presently consume alcoholic beverages? If 'YES', please complete the following:	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

Quantity: Beer: _____ Wine: _____ Liquor: _____

Check one: ◯ Daily ◯ Weekly ◯ Monthly

(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.	◯ Yes ◯ No	◯ Yes ◯ No

7. Is any individual to be insured now using or has ever used the following drugs: Heroin, Morphine, Methadone, Fentanyl, Hydrocodone, Oxycodone/ Perocet, Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital, Hashish, Cannabis, Dexedrine, Crystal, Ecstasy, MDMA, Speed, Meth, Cocaine, Acid, LSD, PCP, Mescaline, Peyote, Psilocybin, Mushrooms, Solvents, Anabolic Steroids?	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

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.	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

(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?	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

10. Driving History - Has any individual had:	Life Insured	Policy Owner
(a) more than 2 driving violations in the past 3 years? If 'YES', please provide details including dates and types of violations in question 12.	◯ Yes ◯ No	◯ Yes ◯ No
(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.	◯ Yes ◯ No	◯ Yes ◯ No
(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.	◯ Yes ◯ No	◯ Yes ◯ No
(d) Do you have a valid Driver's License? If 'NO', provide details in question 12.	◯ Yes ◯ No	◯ Yes ◯ No
(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: _____	◯ Yes ◯ No	◯ Yes ◯ No

11. Since the policy was originally applied for, has any individual to be insured:	Life Insured	Policy Owner
(a) had any illness, disease, operation or injury?	◯ Yes ◯ No	◯ Yes ◯ No
(b) consulted or been attended by a physician or other practitioner?	◯ Yes ◯ No	◯ Yes ◯ No
(c) have any reason to believe he/she is not in good health?	◯ Yes ◯ No	◯ Yes ◯ No

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?	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ 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 ☐ Death before age 40 ☐ any other hereditary disease

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

Life Insured	Disease	Age at Onset	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 Onset	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: (a) THE EARS, EYES, NOSE, THROAT, LUNGS including:	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ sleep apnea ☐ sarcoidosis ☐ cystic fibrosis ☐ shortness of breath ☐ persistent cough ☐ coughing up blood
☐ asthma ☐ bronchitis ☐ COPD ☐ optic neuritis ☐ any other eye, ear, nose, throat, or lung disorder

If 'YES' to bronchitis or asthma, please complete Bronchitis or Asthma Questionnaire.

(b) THE HEART, ARTERIES OR OTHER PARTS OF THE CARDIOVASCULAR SYSTEM including:	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ angina ☐ chest pain ☐ elevated cholesterol ☐ palpitation ☐ irregular pulse ☐ aneurysm ☐ high blood pressure
☐ rheumatic fever heart murmur ☐ heart attack ☐ bypass or angioplasty ☐ pacemaker ☐ peripheral vascular disease
☐ abnormal EKG ☐ abnormal echocardiogram ☐ any other disease or disorder of the heart or blood vessels

(c) THE ABDOMINAL ORGANS including:	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ ulcer ☐ hernia ☐ ulcerative colitis ☐ rectal bleeding or blood in stool ☐ Crohn's disease ☐ hepatitis
☐ jaundice ☐ liver disease ☐ cirrhosis ☐ chronic diarrhea ☐ pancreatitis ☐ colon polyps
☐ any other disease or disorder of the bowel, stomach, pancreas or liver

(d) THE KIDNEYS, BLADDER and REPRODUCTIVE ORGANS including:	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ nephritis ☐ blood, pus, sugar or protein in urine ☐ kidney stones ☐ breast disorder or unusual discharge
☐ abnormal mammogram or breast ultrasound ☐ abnormal PAP ☐ elevated PSA (prostate specific antigen)
☐ any other disease or disorder of kidneys, bladder or reproductive organs

(e) THE BRAIN AND NERVOUS SYSTEM including:	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ epilepsy ☐ seizures ☐ stroke ☐ transient ischemic attack(TIA) ☐ multiple sclerosis ☐ numbness or tingling of limbs
☐ impairment of speech ☐ autism ☐ impairment of balance ☐ memory impairment ☐ cognitive impairment
☐ fainting spells ☐ paralysis ☐ dementia ☐ Alzheimer's disease ☐ Parkinson's disease
☐ motor neuron disease (including ALS/Lou Gehrig's disease) ☐ coma ☐ head injury ☐ persistent headaches
☐ any other disease of the brain or nervous system

(f) MENTAL HEALTH including: (please include cause if known in question 18 with any other details)	**Life Insured**	**Policy Owner**
	◯ Yes ◯ No	◯ Yes ◯ No

☐ depression ☐ anxiety ☐ panic attacks ☐ PTSD ☐ bi-polar disorder ☐ schizophrenia
☐ developmental delay or disability ☐ eating disorder ☐ chronic fatigue ☐ ADD or ADHD
☐ attempted suicide or suicidal thoughts ☐ any other emotional or psychiatric disorder

(g) THE BLOOD, GLANDS and ENDOCRINE SYSTEM including:	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

☐ anemia ☐ bleeding disorder ☐ blood clot ☐ diabetes ☐ leukemia ☐ night sweats
☐ enlargement of lymph nodes (glands) ☐ unexplained infections ☐ any other endocrine or blood disease or disorder

(h) THE MUSCULO-SKELETAL SYSTEM including:	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

☐ arthritis ☐ rheumatoid arthritis ☐ lupus ☐ amputation ☐ chronic pain ☐ muscular dystrophy
☐ any other disorder of the muscles, bones or joints

(i) THE IMMUNE SYSTEM including:	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

☐ acquired immune deficiency syndrome (AIDS) ☐ AIDS related complex (A.R.C.) ☐ positive HIV test
☐ any other immunological disorder

(j) CANCER, GROWTH and SKIN DISORDERS including:	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

☐ cancer ☐ cyst, tumor, lump, polyp or other growth ☐ abnormal biopsy or pathology result ☐ mole or unusual skin lesion(s)
☐ any other growth or malignancy

15. Other than as disclosed in the answers above, has any individual to be insured:	Life Insured	Policy Owner
(a) Consulted a doctor or medical practitioner within the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
(b) Had an EKG, Blood Test or other diagnostic test within the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
(c) Been a patient in a hospital or other medical facility within the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
(d) Currently awaiting test results or been advised to have any diagnostic test, hospitalization or surgery which has not been completed?	◯ Yes ◯ No	◯ Yes ◯ No
(e) Ever been tested for exposure to the AIDS virus?	◯ Yes ◯ No	◯ Yes ◯ No
(f) Any weight change over 10 lbs (4.5 kg) in the last 12 months?	◯ Yes ◯ No	◯ Yes ◯ No
(g) Requested or received a pension, benefits, disability payment or settlement because of an injury or illness?	◯ Yes ◯ No	◯ Yes ◯ No
(h) Had any health symptoms or complaints for which a physician has **NOT been consulted or treatment received?**	◯ Yes ◯ No	◯ Yes ◯ No

16.	Life Insured	Policy Owner
(a) Is any individual to be insured currently under any treatment or medication?	◯ Yes ◯ No	◯ Yes ◯ No
(b) Do you have any reason to believe you are not in good health?	◯ Yes ◯ No	◯ Yes ◯ No
For Females only: (c) Are you currently pregnant? If so, please provide your due date: _____	◯ Yes ◯ No	◯ Yes ◯ No
(d) Is it a normal pregnancy to date?	◯ Yes ◯ No	◯ Yes ◯ No

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.	Life Insured	Policy Owner
	◯ Yes ◯ No	◯ Yes ◯ No

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. Application for Child Protection Rider

E.1 Application for Insurance– FOR CHILDREN (including those covered under the Child Protection Rider)

Children covered under the Child Protection Rider may include any present or future child to the Life Insured under the base coverage, any step-child or legally adopted child of the Life Insured under the base coverage.

Child 1

Full Name: _____

Date of Birth: _____ Gender: _____

Relationship to Life Insured (for CPR only): ◯ Child ◯ Legally Adopted Child ◯ Step Child ◯ Other: _____

Child 2

Full Name: _____

Date of Birth: _____ Gender: _____

Relationship to Life Insured (for CPR only): ◯ Child ◯ Legally Adopted Child ◯ Step Child ◯ Other: _____

Child 3

Full Name: _____

Date of Birth: _____ Gender: _____

Relationship to Life Insured (for CPR only): ◯ Child ◯ Legally Adopted Child ◯ Step Child ◯ Other: _____

Child 4

Full Name: _____

Date of Birth: _____ Gender: _____

Relationship to Life Insured (for CPR only): ◯ Child ◯ Legally Adopted Child ◯ Step Child ◯ Other: _____

E. Child Protection Rider - Qualifying Questions

If you answer 'Yes' to any of the below questions, the child is ineligible for Child Protection Rider coverage.	**CPR Child Insured**			
	Child 1	**Child 2**	**Child 3**	**Child 4**
1. In the last 2 years, has there been an application for life or critical illness insurance on the child that was declined?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Has the child ever been treated for or had any symptoms or indication of the following: a) Cancer or other malignant disease including leukemia, lymphoma, cancerous tumour or cancerous growth?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
b) Cerebral palsy, muscular dystrophy, autism, Down syndrome, or cystic fibrosis?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
c) Heart or brain surgery or been advised to have heart or brain surgery?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. If the child is 15 years of age or older, has the child: a) been convicted of a criminal offense, had driver's license suspended or any charges pending?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
b) been vaping, or used fentanyl, solvents, heroin, cocaine, hallucinogens, or been treated or counselled for alcohol or drug abuse?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

G. Payment Information (Select one)

Total Modal Premium plus sales tax, if applicable: $ _____ Amount paid with this application: $ _____

◯ **Monthly:** Pre-Authorized Debit (PAD)

◯ **Semi-Annual:** Billing

◯ **Annual:**

◯ Pre-Authorized Debit (PAD) ◯ Billing ◯ Credit Card (Visa, Mastercard)

***Complete PAD/Credit Card section below.**

Pre-Authorized Debit (PAD)

◯ **Use my current Wawanesa Life PAD under:** Policy #: _____ 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 #: _____ Financial Institution Number: _____ Account #: _____

Branch Address: _____

Withdrawal Date: ◯ Policy Date or _____ ◯ Draw premium upon approval.

Credit Card – Only available on select products and annual premium payment

When CHANGING OR UPDATING credit card information for an inforce policy the card holder must be the one to contact our office directly via telephone at 1-800-263-6785 OR complete a new PAYMENT OPTION FORM, signed by the client that MUST be MAILED/COURIERED to our office. We cannot accept this form by email or fax. 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: ◯ Visa ◯ Mastercard Amex, Debit or Prepaid Cards are not accepted.

Card Number (ony provide if mailng form): _____ Expiry Date (only provide if mailing form): _____

Name as it appears on the Credit Card: _____

Cardholder Address: _____

City: _____ Province: _____ Postal Code: _____ Telephone: _____

H. 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 MIB, LLC 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 MIB, LLC.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, LLC, Motor Vehicle Department concerning my 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 Wawanesa Life to release all medically related information obtained during the underwriting process to my personal physician or other medical practitioner.

Pre-Authorized Debit (PAD) Authorization (if applicable – please complete Section G)

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

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 236 Carlton Street, Winnipeg, Manitoba R3C 1P5. 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: Privacy Officer, The Wawanesa Life Insurance Company, 236 Carlton Street, Winnipeg, Manitoba R3C 1P5.

Honesty Disclosure - I confirm that all of my answers to the declarations are truthful and complete to the best of my information, knowledge and belief. I further confirm that I have read, understood and accepted the terms and conditions of the agreements, declarations and authorizations contained in this application.

I agree that a copy of the application I submitted can be shared with my independent insurance agent.

A photocopy or an electronic reproduction of this document will be as valid as the original.

Signing with an electronic signature implies consent for us to conduct business with you electronically and to use e-signatures on document needed to be signed by you or us.

H. Agreement And Declaration / Authorization And Signatures (continued)

Signed at _____ in the province of _____ Date (mm/dd/yyyy): _____

Life Insured, or residing parent if Life Insured is under age 16 (PLEASE PRINT)

Life Insured, or residing parent if Life Insured is under age 16 (SIGNATURE)

Policy Owner Premium Waiver (PLEASE PRINT)

Policy Owner Premium Waiver (SIGNATURE)

Payor(s), if other than the Life Insured or Policy Owner (SIGNATURE)

Policy Owner, if other than Life Insured (PLEASE PRINT)
(if Policy Owner is a company, affix Company Seal and provide signature(s) of authorized signing officer(s))

Policy Owner (SIGNATURE)

Joint Policy Owner (PLEASE PRINT)

Joint Policy Owner (SIGNATURE)

I. Statement by Independent Insurance Broker

Premium Calculations

Base Plan $ _____

Accidental Death Benefit $ _____

Child Critical Illness Rider $ _____

Child Protection Rider $ _____

Disability Waiver of Premium $ _____

Death or Disability Waiver of Premium $ _____
(only applicable on Juvenile policies)

Other: _____ $ _____

Total Premium $ 0

Sales Tax (if applicable) $ _____

Total Amount $ 0

Special Instructions

Contact the insured at: ◯ Home ◯ Other: _____

The best time to contact him/her is: ◯ 9am - 12 noon ◯ 12 noon - 4pm ◯ 4pm - 8pm

Time zone: ◯ PST ◯ MST ◯ CST ◯ EST ◯ AST ◯ NST

Do you have any instructions for contacting the insured?

Independent Insurance Broker's Declaration

I declare that I have asked and fully recorded the answers of all proposed lives insured 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 Disclosure: 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.

☐ I, as the representative agent of the proposed insured, have read and understood the Independent Insurance Broker's Declaration and have to the best of my ability conveyed any required information in full to the proposed insured.

Writing Agent (Please Print): _____

Writing Agent Signature: _____

Allocation of this Sale

	Name (Please Print)	Broker Number	First Year %	Renewal %
Agent of Record				
Servicing Agent				
Other				

Please return form to Wawanesa Life via email, fax, or mail:

Email: lifeservices@wawanesa.com

Fax: 1-888-985-3872

Mail: 236 Carlton Street, Winnipeg, Manitoba R3C 1P5

Tel: 1-800-263-6785

wawanesalife.com

RESET FORM CLEAR PAGE

Application for Reinstatement and/or Change

Notices and Disclosure Statements

Customer Copies

Notice of MIB, LLC

MIB, LLC receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. Therefore, MIB has agreed to protect such information in a manner that is substantially similar to the Company's privacy and security practices, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB's commitment to protect the confidentiality and security of your personal information, you may contact the MIB Privacy Department at privacy@mib.com.

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

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 1-866-692-6901 or go to its website at www.mib.com to request disclosure online. 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 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

We, or, our reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, LLC may be obtained on its website at http://www.mib.com or Canadadisclosure@mib.com

Notice of Investigative Reports

In the processing of the application for insurance, 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, Wawanesa may need to release medically related information obtained 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 agent.

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 agents 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 they accept; the MIB, LLC as explained in 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:

1. We may share medical information collected about you with your doctor.
2. 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.
3. 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 236 Carlton Street, Winnipeg, MB R3C 1P5 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: Privacy Officer, The Wawanesa Life Insurance Company, 236 Carlton Street, Winnipeg, Manitoba R3C 1P5.

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 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.**

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 the financial transaction. Please ask your independent insurance broker for further information or details.

1. I, _____ , am a licensed 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 (mm/dd/yyyy): _____ Independent Insurance Broker Signature: _____