Group Insurance: Evidence of Insurability

1. All questions must be answered in the same color of ink – Black (for scanning purposes). **Please Print**
2. Any changes or errors must be initialed by the employee and dated. Do not use White-Out
3. Please note that this insurance will not be effective until approved by Western Life Assurance Company
4. It is important to answer questions completely & accurately, failure to do so may results in denial and/or loss of coverage.

Part 1 – Policyholder Information

Policyholder (Group Name & Number):				
Enrollment:	❑Employee	❑Dependents	❑Dependent Life	
Benefits:	❑Life	❑Extended Health	❑Critical Illness (CI)	❑Short Term Disability (STD)	❑Long Term Disability (LTD)

Part 2 – Employee Information

Last Name:	First Name:		
Address:	City:	Province:	Postal Code:
Telephone/Cell #:	Occupation:		
Email Address:			
Date of Birth (DD/MM/YY):	Age:	Height (ft/in):	Weight (lbs):

Part 3 – Dependent Information

	Last Name	First Name	Age	Date of Birth (DD/MM/YY)	Gender (M/F)	Relationship to Employee	Height (ft/in)	Weight (lbs)
Spouse					❑M ❑F			
Dep. A					❑M ❑F			
Dep. B					❑M ❑F			
Dep. C					❑M ❑F			

Part 4 – Declaration of Insurability (review for accuracy before signing)

	Have you or your spouse or dependent(s) ever had or been treated for any illness or disorder affecting the following **(circle conditions which apply):**	Employee Yes/No	Spouse Yes/No	Children Yes/No	Date, treatment, medication, results, doctor/hospital
a.	**Heart and blood** such as: high cholesterol, abnormal blood pressure, stroke, heart attack, poor circulation or other disorder of the heart, blood or blood vessels?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
b.	**Digestive system** such as: disorder of stomach, intestines, colitis or ulcers, liver, hepatitis, pancreas, gallbladder?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
c.	**Glandular system** such as: allergies, anemia, diabetes, skin disorders or thyroid disorders, other diseases of the glands or disorder of breast?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
d.	**Immune system** such as: AIDS or other disorders of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
e.	**Musculo-skeletal system** such as: arthritis, rheumatism, gout, bones or joints, back/neck or any other disorders of the muscles?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
f.	**Nervous system** such as: ADHD (attention deficit hyperactivity disorder), mental and emotional disorders (anxiety, chronic fatigue syndrome, depression), epilepsy, multiple sclerosis, hereditary disease or any other disorder of the brain or nervous system?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
g.	**Respiratory system and sense organs** such as: disorder of ears, eyes, nose, throat, asthma, sleep apnea or any other respiratory/lung disorder?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
h.	**Urinary and reproductive system** such as: kidney stone or colic, or any other disorder of kidneys, bladder, reproductive organs or prostate gland?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
i.	**Other than above**: tumour, leukemia, cancer or other growth or malignant disease?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
j.	Have you or your named dependent(s) taken drugs for other than medical purposes, received treatment for alcohol or drug dependency, received family counselling or any other professional counselling currently or during the past 3 years?	❑Y ❑N	❑Y ❑N	❑Y ❑N	

Part 4 – Declaration of Insurability (continued)

		Employee Yes/No	Spouse Yes/No	Children Yes/No	Date, treatment, medication, results, doctor/hospital
k.	Have you any reason to believe that you or your above named dependent(s) will require medical or surgical treatment during the next 12 months?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
l.	Have you or your above named dependent(s) ever been declined, postponed or modified in any way for life or disability insurance?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
m.	Have you or your named dependent(s) ever been off work more than 15 days or ever made a claim or received benefits for an accident or sickness?	❑Y ❑N	❑Y ❑N	❑Y ❑N	
n.	Do you or your named dependent(s) have any mental or physical impairment or any deformity?	❑Y ❑N	❑Y ❑N	❑Y ❑N	

Part 5 – Last Physician Visit (This section MUST be completed)

	Last Name	First Name	Name of Physician or Practitioner	Reason/Results for Last Consultation	Date (MM/YY)
Employee					
Spouse					
Dep. A					
Dep. B					
Dep. C					

Part 6 – MIB Pre-Notice

MIB 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. Western Life Assurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life 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 also arrange disclosure of any information it may have in your file. If you question the accuracy of the 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: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7, Telephone Number: (416) 597-0590

Western Life Assurance Company or its reinsurer(s) may also release information from 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 may be obtained on its website at www.mib.com.

Part 7 – Declaration and Authorization

I declare that all the information shown above and on the reverse side of this application are complete and true to the best of my knowledge and belief. I agree that they shall be taken as the basis of the issuance of the insurance for me and my named dependents and that the Insurance Company may withdraw the insurance coverage for which I am applying and may consider such coverage as having never been in effect, if any information is substantially incomplete or incorrect. I also agree that if Weekly Income (WI) or Long Term Disability (LTD are applied for, this Health Statement shall form part of the Weekly Income and/or Long Term Disability Contract.

I authorize Western Life Assurance Company, or its reinsurers to make a brief report of my personal health information to MIB, Inc. ("MIB").

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Western Life Assurance Company, or its reinsurers, any such information.

A photocopy of this consent has the same value as the original.

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 Western Life Assurance 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@westernlife.com or by calling 1-888-647- 5433 and asking to speak to the Privacy Office.

I, the Employee, have received, read and understand the MIB Pre-Notice and have been instructed to keep a copy of this application which includes that notice.

Signature of Employee: Date (DD/MM/YY)

Western FINANCIAL GROUP

Complete and send to:
Western Financial Group Insurance Solutions
201-600 Empress Street, Winnipeg, Manitoba R3G 0R5
Toll Free: 1-800-665-8990 **Fax:** 204-943-5531