Group Insurance: Excess and Late applicants

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 result in denial and/or loss of coverage.

Part 1 – Policyholder Information

Policyholder (Group Name & Number):
Benefits Applied for: ❑Life ❑Extended Health ❑Short Term Disability (STD) ❑Long Term Disability (LTD) ❑Critical Illness Excess ❑ Late ❑ If late, please advise reason:
Has employee been covered by a Western Life group health plan or individual policy during the past 5 years? ❑Yes ❑No If yes, provide details:
Employee Monthly Salary: $

Part 2 – Employee Information

Last Name:	First Name:	Initial:	Sex: Male ❑ Female ❑
Address:	City:	Province:	
Telephone #	Occupation:		
Email Address:			
Date of Birth: (DD/MM/YY)	Age:	Height (ft/in):	Weight (lbs):
Have you had any weight change over 15 lbs in the last 12 months? ❑Y ❑ N **If yes, please provide amount and reason:**			
Have you been absent from work more than 7 consecutive days during the past 3 years because of illness or injury? ❑Y ❑N **If yes, please provide reason:** Are you currently at work and able to perform all of your regular duties? ❑Y ❑N **If no, please provide reason:**			

Part 3 – Physician Information

Name of Personal Physician or Healthcare Clinic:	Date last seen: DD/MM/YY
Reason for visit:	Treatment & results:

Part 4 – Medical History (review for accuracy before signing)

	#1. Have you ever had, been told you had, or received treatment for any illness or disorder affecting the: (circle which conditions apply)	**Yes/No**	**Date, treatment, medication, results, doctor/hospital**
a.	**Cardiovascular system** such as: heart attack, stroke, angina or chest pain, high blood pressure, heart murmurs, irregular heartbeat, blood clot, poor circulation or other disorder of the heart or blood vessels?	❑Y ❑N	
b.	**Respiratory system** such as: shortness of breath, sleep apnea, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other disorder of lungs, nose or throat?	❑Y ❑N	
c.	**Nervous system and Sense organs** such as: ADHD (attention deficit hyperactivity disorder), anxiety, dizziness, fainting, headaches, epilepsy or convulsions, multiple sclerosis, paralysis or stroke, nervous breakdown, burn out, depression, brain or spinal cord or disorder of skin, sight, hearing or other disorder of senses?	❑Y ❑N	
d.	**Digestive system** such as: any disorder of the stomach, intestines, rectum, liver, gallbladder, pancreas, hepatitis, indigestion, ulcer, hernia, colitis, diverticulitis or any bleeding of the stomach, intestines or rectum?	❑Y ❑N	

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e.	**Urinary and Reproductive systems** such as: sugar in urine or other abnormalities of urine, sexually transmitted disease, stones or other disorder of the kidney, bladder, disorder of prostate or reproductive organs?	❑Y ❑N	
f.	**Glandular system and Blood** such as: diabetes, thyroid, pituitary or other glands, high cholesterol levels, gout, enlarged glands, anemia, disorder of breasts, skin condition or allergy?	❑Y ❑N	
g.	**Musculo-skeletal system** such as: arthritis, sciatica, rheumatism, rheumatic fever, back, spine, or disc trouble, joint or bones or any other disorder of muscles, joints, neck or back?	❑Y ❑N	
h.	**Immune system** such as: AIDS, ARC (Aids Related Complex), chronic diarrhea, unusual skin lesions, multiple chronic unexplained infections?	❑Y ❑N	
#2.	**Answer and circle which conditions apply:**	**Yes/No**	**Date, treatment, medication, results, doctor/hospital**
a.	Have you ever been advised to follow a special diet or undergo treatment for any condition or are you presently taking any medication (including herbal)? If yes, advise name of medication	❑Y ❑N	
b.	Have you ever had or been told you have a cyst, tumour, leukemia, cancer or unusual growth in any part of the body?	❑Y ❑N	
c.	Have you ever had test results indicating exposure to the AIDS virus, or received any related medical advice or treatments?	❑Y ❑N	
d.	Have you ever used drugs such as heroin, cocaine, LSD, barbiturates, amphetamines, marijuana, or other hallucinogenic, narcotic, or addictive drugs or other drugs except as prescribed by a physician?	❑Y ❑N	
e.	Have you ever received advice, counselling or treatment, or belonged to an organization because of the use of alcohol or drugs?	❑Y ❑N	
f.	Have you ever been declined, rated, modified or postponed for life or health insurance or had any health insurance policy cancelled or non-renewed? If yes, give companies, dates and reasons for such action.	❑Y ❑N	
g.	In the past 5 years, except as mentioned, have you had an electrocardiogram, x- ray or other diagnostic test?	❑Y ❑N	
h.	In the past 5 years, except as mentioned, consulted a doctor or chiropractor for any reason or been a patient in a hospital?	❑Y ❑N	
i.	Do you drink alcoholic beverages? If yes, indicate average weekly amount.	❑Y ❑N	
j.	Have any of your immediate family members (father, mother, siblings) had cancer, heart disease, stroke, diabetes, polycystic kidney disease, diabetes, Huntington's Chorea, multiple sclerosis, Alzheimer disease, motor neuron disease, Parkinson's disease, muscular dystrophy, or any other hereditary disease prior to age 60?	❑Y ❑N	
k.	If applicable, had any menstrual disturbance or complicated pregnancy?	❑Y ❑N	
l.	Are you pregnant? If yes, provide expected date of delivery.	❑Y ❑N	
#3.	**Are you aware of:**	**Yes/No**	**Date, treatment, medication, results, doctor/hospital**
a.	Any symptoms or physical anomaly that is not disclosed in question #1 and #2?	❑Y ❑N	
b.	Any planned or pending treatment?	❑Y ❑N	
c.	Any tests or investigation, hospitalization or surgery recommended, but not yet complete?	❑Y ❑N	
d.	Any outstanding test results?	❑Y ❑N	

Part 5 – 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 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 6 – 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 Short Term Disability (STD) or Long Term Disability (LTD) are applied for, this Health Statement shall form part of the Short Term Disability 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 LIFE ASSURANCE

Attn:
Western Financial Group Insurance Solutions
201-600 Empress Street., Winnipeg, MB R3G 0R5
Phone 1-800-665-8990 **Fax** 204-943-5531