

# Group Insurance: Evidence of Insurability

(Please complete both sides)



Part 1 – Policyholder Information					
Policyholder (Group Name & Number):					
Enrollment:	<input type="checkbox"/> Employee	<input type="checkbox"/> Dependents	<input type="checkbox"/> Dependent Life	<input type="checkbox"/> First in Line	
Benefits:	<input type="checkbox"/> Life	<input type="checkbox"/> Extended Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Weekly Income (WI) <input type="checkbox"/> 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)
A.					<input type="checkbox"/> M <input type="checkbox"/> F			
B.					<input type="checkbox"/> M <input type="checkbox"/> F			
C.					<input type="checkbox"/> M <input type="checkbox"/> F			
D.					<input type="checkbox"/> M <input type="checkbox"/> F			

Part 4 – Declaration of Insurability (To be completed by the employee)					
CIRCLE conditions which apply in the left hand column and provide details.					
	Have you or your spouse or dependent(s) ever had or been treated for any illness or disorder affecting the following:	Employee Yes/No	Spouse Yes/No	Children Yes/No	Provide details: date, treatment, results, doctor/hospital
a.	<b>Heart and blood such as:</b> high cholesterol, abnormal blood pressure, stroke, heart attack, poor circulation or other disorder of the heart, blood or blood vessels?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
b.	<b>Digestive system such as:</b> disorder of stomach, intestines, colitis or ulcers, liver, hepatitis, pancreas, gallbladder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
c.	<b>Glandular system such as:</b> allergies, anemia, diabetes, skin disorders or thyroid disorders, other diseases of the glands or disorder of breast?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
d.	<b>Immune system such as:</b> AIDS or other disorders of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
e.	<b>Musculo-skeletal system such as:</b> arthritis, rheumatism, gout, bones or joints, back/neck or any other disorders of the muscles?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
f.	<b>Nervous system such as:</b> mental and emotional disorders (anxiety, chronic fatigue syndrome, depression), epilepsy, multiple sclerosis, hereditary disease or any other disorder of the brain or nervous system?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
g.	<b>Respiratory system and sense organs such as:</b> disorder of ears, eyes, nose, throat, asthma, sleep apnea or any other respiratory/lung disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
h.	<b>Urinary and reproductive system such as:</b> kidney stone or colic, or any other disorder of kidneys, bladder, reproductive organs or prostate gland?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
i.	<b>Other than above:</b> tumour, leukemia, cancer or other growth or malignant disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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(over)

\*\*\*Please Detach and Keep This Notice\*\*\*

### MIB Pre-Notice

- Information regarding your insurability will be treated as confidential. Western Life Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.
- Upon receipt of a request from you, MIB will also arrange disclosure of any information in your file.
- If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB information office is:

MIB Information Office  
 330 University Avenue, Suite 501  
 Toronto, Ontario, M5G 1R7  
 Telephone #: (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](http://www.mib.com).

Part 5 – Declaration of Insurability (Continued)					
	Additional Information	Employee Yes/No	Spouse Yes/No	Children Yes/No	If Yes, give full details
a.	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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
b.	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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
c.	Have you or your above named dependent(s) ever been declined, postponed or modified in any way for life or disability insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
d.	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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
e.	Do you or your named dependent(s) have any mental or physical impairment or any deformity?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

**Part 6 – Last Physician Visit**

Provide information below for Applicant, Spouse and All Dependent Children. **This section MUST be completed.**

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

**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 any physician or health care professional, hospital or other medically related facility and the MIB, Inc. Formerly known as Medical Information Bureau, as well as any other insurance company, to provide and exchange any medical information with Western Life Assurance Company and its reinsurers for the risk assessment or the investigation relating to underwriting and the study of any claim for me or my dependents.

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](mailto:privacy@westernlife.com) or by calling 1-888-647-5433 and asking to speak to the Privacy Office.

Signature of Employee:	Date (DD/MM/YY)
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	<p>Complete and send to:</p> <p><b>Western Financial Group Insurance Solutions</b>  <b>777 Portage Avenue, Winnipeg, MB R3G 0N3</b>  <b>Toll Free: 1-800-665-8990 Fax: 204-975-1624</b></p>	<p><i>Western Financial Group (Network) Inc.</i></p>

\*\*\*This Stub must be detached and retained by the Employee\*\*\*

**Checklist**

Please review this checklist to be sure your form is complete. If all the requested information is not provided, the form will be returned to you for completion. This will result in a delay in processing your enrolment.

- All questions must be answered in the same colour of ink
- Any changes or errors must be initialled by the employee and dated. Do not use White-Out.
- Provided full details to all the medical questions, including dates and the present condition of any injuries or ailments.
- Sign and date the declaration and authorization.
- Detach and keep Notice of Medical Information Bureau.
- **Please note that this insurance will not be effective until approved by Western Life Assurance Company.**