

Group Insurance: Excess

(Please complete both sides)



Part 1 – Policyholder Information		
Policyholder (Group Name & Number):		
Benefits Applied for: <input type="checkbox"/> Life \$	<input type="checkbox"/> Weekly Income (WI) \$	<input type="checkbox"/> Long Term Disability (LTD) \$
Has employee been covered by a Western Life group health plan or individual policy during the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:		
Employee Monthly Salary: \$		

Part 2 – Employee Information			
Last Name:		First Name:	
Address:		City:	Province: Postal Code:
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? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please provide reasons below:			
Have you been absent from work more than 7 consecutive days during the past 3 years because of illness or injury? <input type="checkbox"/> Y <input type="checkbox"/> N			

Part 3 – Physician Information	
Do you have a regular or family physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details below. If no, provide details of last doctor consulted.	
Doctor:	Address:
Date last seen: DD/MM/YY	Reasons for visit, treatment & results:

Part 4 – Medical History		
	Yes/No	Provide details: date, treatment, results, doctor/hospital
#1. Have you ever had, been told you had, or received treatment for any illness or disorder affecting the: (circle which conditions apply)		
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?	<input type="checkbox"/> Y <input type="checkbox"/> N	
b. Respiratory system such as: shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other disorder of lungs, nose or throat?	<input type="checkbox"/> Y <input type="checkbox"/> N	
c. Nervous system and Sense organs such as: 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	
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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	
g. Musculo-skeletal system such as: arthritis, sciatica, rheumatism, rheumatic fever, back, spine, or disc trouble, join or bones or any other disorder of muscles, joints, neck or back?	<input type="checkbox"/> Y <input type="checkbox"/> N	
h. Immune system such as: AIDS, ARC (Aids Related Complex), chronic diarrhea, unusual skin lesions, multiple chronic unexplained infections?	<input type="checkbox"/> Y <input type="checkbox"/> N	

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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.

Part 4 – Medical History continued		
	Yes/No	Provide details: date, treatment, results, doctor/hospital
#2. Have you:		
a.	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.	<input type="checkbox"/> Y <input type="checkbox"/> N
b.	Ever had or been told you have a cyst, tumour, leukemia, cancer or unusual growth in any part of the body?	<input type="checkbox"/> Y <input type="checkbox"/> N
c.	Ever had test results indicating exposure to the AIDS virus, or received any related medical advice or treatments?	<input type="checkbox"/> Y <input type="checkbox"/> N
d.	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?	<input type="checkbox"/> Y <input type="checkbox"/> N
e.	Ever received advice, counselling or treatment, or belonged to an organization because of the use of alcohol or drugs?	<input type="checkbox"/> Y <input type="checkbox"/> N
f.	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.	<input type="checkbox"/> Y <input type="checkbox"/> N
#3. Have you:		
a.	In the past 5 years, except as mentioned, had an electrocardiogram, x-ray or other diagnostic test or been advised to have any investigation, hospitalization or surgery, which has not been completed?	<input type="checkbox"/> Y <input type="checkbox"/> N
b.	In the past 5 years, except as mentioned, consulted a doctor or chiropractor for any reason or been a patient in a hospital?	<input type="checkbox"/> Y <input type="checkbox"/> N
c.	Do you drink alcoholic beverages? If yes, indicate average weekly amount.	<input type="checkbox"/> Y <input type="checkbox"/> N
d.	In your immediate family, any history of high blood pressure, stroke, heart or kidney disease, diabetes, mental or nervous disorder, or suicide?	<input type="checkbox"/> Y <input type="checkbox"/> N
e.	If applicable, had any menstrual disturbance or complicated pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N
f.	Are you pregnant? If yes, provide expected date of delivery.	<input type="checkbox"/> Y <input type="checkbox"/> N

Part 5 – Declaration and Authorization	
<p>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.</p> <p>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.</p> <p>A photocopy of this consent has the same value as the original.</p> <p>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.</p>	
Signature of Employee:	Date (DD/MM/YY):
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  <p>Western FINANCIAL GROUP</p> </div> <div style="text-align: center;"> <p>Complete and send to:</p> <p>Western Financial Group Insurance Solutions 201-600 Empress Street, Winnipeg, Manitoba R3G 0R5 Toll Free: 1-800-665-8990 Fax: 204-975-1624</p> </div> <div style="text-align: right; font-size: small;"> <p>Western Financial Group (Network) Inc.</p> </div> </div>	

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This Stub must be detached and retained by the Employee

Checklist
<p>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.</p> <ul style="list-style-type: none"> • All questions must be answered in the same colour of ink • Any changes or errors must be initialled by the employee and dated. <u>Do not use White-Out.</u> • Provided <u>full</u> 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.