



POLICYHOLDER (GROUP NAME & NUMBER:)

ENROLLMENT: Employee Dependents Dependent Life First in Line

BENEFITS: Life Extended Health Dental * Critical Illness Weekly Income (WI)*+
 Long Term Disability (LTD)*+

* Applicable only if coverage appears on Master Policy.
+ Weekly Income and Long Term Disability coverage not available for dependents.

Please print or type

1. Employee's Name _____ Occupation _____
Date of Birth _____ Age _____ Height _____ Weight _____

2.

Full Name of Dependent	Relationship to Employee	Date of Birth	Age	Height	Weight
A.					
B.					
C.					
D.					

DECLARATION OF INSURABILITY (TO BE COMPLETED BY EMPLOYEE)

3. **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 IN LEFT HAND COLUMN and provide details)**

Medical History	Yes	No	Emp/Sp/Dep	Provide details: date, treatment, results, doctor/hospital
a. Heart and blood such as: high cholesterol, abnormal blood pressure, stroke, heart murmur, angina or chest pain, heart attack, poor circulation or other disorder of heart, blood or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
b. Digestive system such as: disorder of stomach, intestines, colitis or ulcers, liver, hepatitis, pancreas, gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
c. Glandular system such as: allergies, anemia, diabetes, skin disorders or thyroid disorders, other diseases of the glands or disorder of breast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
d. Immune system such as: AIDS or other disorders of the immune system, or test results indicating exposure to the AIDS virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
e. Musculo-skeletal system such as: arthritis, rheumatism, gout, bones or joints, back/neck or any other disorders of the muscles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
f. Nervous system such as: 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"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
g. Respiratory system and sense organs such as: disorder of ears, eyes, nose, throat, asthma, sleep apnea or any other respiratory/lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
h. Urinary and reproductive system such as: kidney stone or colic, or any other disorder of kidneys, bladder, reproductive organs or prostate gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
i. Other than above: tumour, leukemia, cancer or other growth or malignant disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

(over)

PLEASE DETACH AND KEEP THIS NOTICE

NOTICE OF MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file you may contact the Bureau and seek a correction. The address of the Bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.

We or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

We may make reports to the MIB regarding factors affecting your insurability. Underwriting decisions, however, are not reported to the MIB. If you apply to another Bureau member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, provide that company with information in its file.

DECLARATION OF INSURABILITY (continued)

4. 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?
 Yes No If Yes, give full details
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5. Have you any reason to believe that you or your above name dependent(s) will require medical or surgical treatment during the next 12 months?
 Yes No If Yes, give full details
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6. Have you or your above named dependent(s) ever been declined, postponed or modified in any way for life or disability insurance?
 Yes No If Yes, give full details
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7. 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?
 Yes No If Yes, give full details
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8. Do you or your named dependent(s) have any mental or physical impairment or any deformity?
 Yes No If Yes, give full details

9. PROVIDE INFORMATION BELOW FOR APPLICANT, SPOUSE, AND ALL DEPENDENT CHILDREN. (THIS SECTION MUST BE COMPLETED)

Name	Name of Physician or Practitioner	Reason/Results for Last Consultation	Date (Month/Year)
A.			
B.			
C.			
D.			

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) coverage 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 Medical Information Bureau, as well as any 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 or by calling 1-888-647-5433 and asking to speak to the Privacy office.

WHEN USED...

- (a) This form is used in the enrolment of all employees and their dependents where the underwriting rules for that size or type of group requires evidence of insurability for the enrolment of the firm.
 (b) It is also used in the same cases for changes from one plan to another better plan.
- This form is completed for any employee (and his/her dependents) who enrolls for Group Insurance more than 31 days after the date he/she first became eligible (i.e., more than 31 days after completing the waiting period for new employees).
- This form is completed for dependents only, where dependent's coverage is added more than 31 days after the employee first acquires eligible dependents.
- This form is completed for an employee, enrolled as a dependent, who wishes to enroll as an employee and the underwriting rules require evidence of insurability to make such a change.

Date _____ Signature of employee _____ Witness _____
WESTERN LIFE ASSURANCE COMPANY Mailing Address: P.O. Box 3300, Winnipeg, Manitoba R3C 5S2
 Telephone 204-784-6900 or 888-647-LIFE (5433) Fax 204-783-6913

THIS STUB MUST BE DETACHED AND RETAINED BY THE EMPLOYEE

<p>CHECKLIST</p> <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 same colour of ink. • Any changes or errors must be initialled by the employee and witnessed. DO NOT USE WHITE-OUT. • Provided FULL details to all the medical questions, including dates and the present condition of any injuries or ailments. • Signed, dated and witnessed declaration. • Detach and keep Notice of Medical Information Bureau.
