

GENERAL INFORMATION

LIFE INSURED (PRINT)

DATE OF BIRTH

 / /

AGE

SEX

M F

POLICYOWNER, if other than Life Insured (PRINT) MR. MRS. MISS MS

SOCIAL INSURANCE NUMBER

POLICYOWNER ADDRESS – NUMBER, STREET, CITY, PROVINCE

POSTAL CODE

BENEFICIARY

RELATIONSHIP

TRUSTEE (if beneficiary is under age 18)

CONTINGENT BENEFICIARY in the event of the death of the beneficiary, the contingent beneficiary will be:

RELATIONSHIP

Is this policy intended to replace any life insurance currently in effect? Yes No **If 'YES', a replacement form must be completed.**

QUALIFYING QUESTIONS

1. Within the last two years, have you had a stroke, heart attack or been advised to have heart surgery? Yes No
2. Within the last three years, have you consulted a physician for, or received treatment for cancer? Yes No
3. Within the last three years, have you been declined for individual life insurance by Wawanesa Life or any other insurer? Yes No
4. Have you been diagnosed, treated for, or had any indication of AIDS or AIDS related complex? Yes No
5. Are you currently restricted to a wheel chair, bedridden, hospitalized or confined to a nursing home requiring full time care? Yes No

IF YOU ANSWERED 'YES' TO ANY OF THE ABOVE FIVE QUESTIONS, COVERAGE IS NOT AVAILABLE.

POLICY BENEFITS

COVERAGE AMOUNT (Maximum \$50,000 coverage per person)

- \$5,000 \$7,500 \$10,000 \$12,500 \$15,000 \$17,500
 \$20,000 \$22,500 \$25,000 \$27,500 \$30,000 \$32,500
 \$35,000 \$37,500 \$40,000 \$42,500 \$45,000 \$47,500
 \$50,000

PAYMENT OPTIONS

- PRE-AUTHORIZED DEBIT*: Monthly Semi-Annual Annual
 or Billing: n/a Semi-Annual Annual
 Modal Premium \$

*Please complete Pre-Authorized Debit section below.

PRE-AUTHORIZED DEBIT (P.A.D.) (if applicable)

Account Owner Name Account Owner Phone #

Account Owner Address (if different from Policyowner)

Use my current Wawanesa Life P.A.D. under policy # or PAD # or

Establish a new P.A.D. using: Details from initial premium cheque Details from VOID cheque (attached) Information provided below:

Type of Account (must allow electronic debits): Chequing Savings Withdrawal date: Policy date or (1st – 28th)

Financial Institution Branch Address

Transit No. F.I. No. Account No.

CUT ALONG DOTTED LINE

RECEIPT FOR PAYMENT

The Wawanesa Life Insurance Company acknowledges receipt of \$ for life insurance applied for on the life of

ADVISOR/BROKER (Signature) _____

Date _____



CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

I consent to Wawanesa Life collecting, using and disclosing my personal information for the purposes of: establishing and maintaining communications with me; underwriting risks on a prudent basis; investigating and paying claims; receiving payments of insurance premiums and policy loan repayments; depositing funds into my account; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law.

I recognize that in providing services to me in the future and providing me with the benefits included in the policy I am applying for, Wawanesa Life may need to collect, use and disclose additional personal information about me. I confirm that this consent applies to that personal information as well.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

PRE-AUTHORIZED DEBIT (P.A.D.) PLAN AUTHORIZATION (if applicable)

I request and authorize Wawanesa Life to make withdrawals from the account designated on page 1 of this application or from any subsequently designated account in order to make policy payments and/or specific payments on loan indebtedness, under the following terms:

1. Withdrawals will be made according to the payment frequency indicated on the application on the policy issue date unless a particular withdrawal day is specified.
2. If a monthly PAD is returned as insufficient funds, the next PAD amount will be for the two months of premium. Notification will be provided prior to this double withdrawal.
3. I may revoke my authorization at any time, subject to providing written notice of 10 days to Wawanesa Life. *(For more information on your right to cancel a PAD agreement, contact your financial institution or visit www.cdnpay.ca.)*
4. I have certain recourse rights, provided under the personal PAD agreement, if any debit does not comply with the agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with the personal PAD agreement. *(For more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.)*
5. I may provide written request to add/delete policies to the PAD agreement or change bank information without completing a new PAD agreement.
6. I waive the right to receive 10 days' notice of an increase or decrease in the amount of the automatic withdrawal due to premium changes during the underwriting process. Notification of premium changes will be provided when the policy is issued.

SIGNATURES

Signed at _____ in the province of _____ on this _____ day of _____.

LIFE INSURED (Signature)

POLICYOWNER, if other than Life Insured (Signature)

P.A.D. ACCOUNT HOLDER, if other than the Policyowner or Life Insured (Signature)

ADVISOR/BROKER (Signature)

POLICY DELIVERY OPTIONS

Policy should be mailed to: Policyowner (direct delivery) or Agent (personal delivery)

If no preference is indicated, policy will be sent directly to the policyowner.

ALLOCATION OF THIS SALE

		ALLOCATION FACTORS	
		FIRST YEAR	RENEWAL
Charles Taub	C9074	100 %	100 %
AGENT OF RECORD (Please print)	BROKER NUMBER		
Charles Taub	C9074	100 %	100 %
SERVICING AGENT (Please print)	BROKER NUMBER		
OTHER (Please print)	BROKER NUMBER	_____ %	_____ %

THE WAWANESA LIFE INSURANCE COMPANY
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TOLL FREE 1-800-263-6785
FAX 1-888-985-3872