





**Section 2: Add or Remove Eligible Dependents (Continued)**

**\* Other Insurance: Co-ordination of Benefits**

If your family members have insurance coverage under any other plan providing similar benefits, your benefits will be coordinated according to industry guidelines so that the total payments under all plans do not exceed 100% of eligible expenses. You must declare other coverage by completing the "Other Insurance" columns for any of your eligible dependents covered under another plan.

If your spouse has other coverage, place an S (Wawanesa plan is considered the Secondary plan) in the Other Insurance column. If your dependent children are covered under another plan, place an S if your birthdate falls later in the year than the birthdate of your spouse. (e.g. If your birthdate is in June and your spouse's birthdate is in March, place an S in the Other Insurance column.)

In situations of divorce or separation, if you have custody of a dependent child, Wawanesa Life will be considered the Primary (first) plan. If you do not have custody, and other insurance coverage exists for your child, place an S in the Other Insurance column. (The plan of the parent with custody of the child will be the primary plan.)

**Section 3: Change of Name**

Please be advised that my name has changed from:

Surname \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

to:

Surname \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Effective: \_\_\_\_\_  
Year/Month/Day

The Reason for the Name Change:  Marriage  Divorce  Other

Note: A Change of Name due to a change in Martial Status may also require a change in Dependent coverage. Please review Sections 1 and 2.

**Section 4: Refusal of Health and/or Dental Benefits**

I have been offered the opportunity to join the firm's Group Insurance Plan and the benefits provided by this Plan have been explained to me. However, I **decline** to participate in the following benefits:

I decline Extended Health for:  Myself and my dependents  My dependents ONLY  
I decline Dental for:  Myself and my dependents  My dependents ONLY

Note: Coverage can only be refused if you and/or dependents are covered by similar group benefits through your spouse's employer.

Spousal Insurer's Name: \_\_\_\_\_ Plan Number: \_\_\_\_\_

If you lose spousal coverage, you **must** apply for coverage under this Plan within 31 days of loss of coverage.

If you apply for coverage after 31 days, you may be required to provide evidence of insurability and your dental benefits will be restricted.

**Section 5: Refusal of All Benefits - For Voluntary Plans Only**

I have been offered the opportunity to join the firm's Group Insurance Plan and the benefits provided by this Plan have been explained to me. However, I **decline to participate in ALL BENEFITS.**

Please date and sign below to indicate your refusal to participate in the Group Insurance Plan.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

If you wish to join the benefit plan at a later date, you will be required to provide evidence of insurability and your dental benefits will be restricted.

**Section 6: Notice Regarding Personal Information**

You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 200 - 191 Broadway, Winnipeg, MB R3C 3P1 or at [www.wawanesalife.com](http://www.wawanesalife.com).

**Section 7: Authorization and Acknowledgement**

I understand that any changes indicated on the Change Form shall not take effect unless this form is received and validated by Wawanesa Life. Changes not reported within 31 days of their effective date may require additional documentation before coverage or changes in coverage can commence.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Head Office use only**

Validated by: \_\_\_\_\_ Date: \_\_\_\_\_