LONG-TERM DISABILITY

PLAN MEMBER STATEMENT

Please return this completed form and supporting documents to:

Wawanesa Life - Claims
236 Carlton St, Winnipeg, MB R3C 1P5
For inquiries, please call: 1-844-318-0411, #4
Fax 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

PLAN MEMBER INFORMATION

Plan Sponsor _____ Group Plan # _____

Plan Member _____
Last Name First Name Initial

Date of Birth_____ Weight _____ Height_____
(yy/mm/dd)

Address _____
Street City Province Postal Code

Phone Number _____ Email _____

I authorize the use of my Social Insurance Number for tax reporting purposes when required in payment of my Group Long-Term Disability benefit.

Social Insurance Number _____ Signature _____

FAMILY INFORMATION

Spouse's Name_____ Date of Birth _____
Last Name First Name (yy/mm/dd)

Is your spouse employed? ☐ Yes ☐ No

Dependent Children:	Date of Birth:	At Home	In School
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No
Last Name First Name	(yy/mm/dd)	☐ Yes ☐ No	☐ Yes ☐ No

CURRENT EMPLOYMENT INFORMATION

Last day worked _____ Job Title_____

Was your job modified, prior to stopping work? ☐ Yes ☐ No If 'Yes', how was it modified?

_____

_____

If your job was modified, why were you unable to continue working?

_____

_____

LTD Plan Member Statement 05 2024

CURRENT EMPLOYMENT INFORMATION continued

How long were you performing the modified work?

Since your last day worked, have you performed any other work? ☐ Yes ☐ No If 'Yes', what dates: _____ (yy/mm/dd) to _____ (yy/mm/dd)

Describe _____

Which duties of your occupation are you unable to perform due to your medical condition?

Are there any other factors preventing or impacting your return to work?

OTHER ACTIVITIES INFORMATION

Have you participated in any school or training? ☐ Yes ☐ No Dates _____ (yy/mm/dd)

Describe _____

Have you participated in any volunteer activities? ☐ Yes ☐ No Dates _____ (yy/mm/dd)

Describe _____

INJURY INFORMATION

Is work absence due to injury: ☐ Yes ☐ No

Type of accident: ☐ Motor vehicle ☐ Work related ☐ Other, explain _____

Where and how did the accident/injury occur? Describe the injury and how it prevents you from working.

Date of accident _____ (yy/mm/dd) Time _____ ☐ AM ☐ PM

Was the occurrence investigated by police? ☐ Yes ☐ No If 'Yes', please attach a copy of the report

Is there any legal action involved? ☐ Yes ☐ No If 'Yes', please provide your lawyer's information

Lawyer's name _____ Phone _____

Lawyer's address _____

OTHER INSURANCE

Insurer's name (eg. Auto, WCB/WSIB/CSST, etc.) _____

Insurance adjuster's name _____

Insurance adjuster's phone number _____ Policy number or claim number _____

ILLNESS INFORMATION

Describe your current condition and how it prevents you from working

_____

_____

_____

What were your first symptoms?

_____

_____

_____

When did you first notice symptoms? _____ (yy/mm/dd)

Have you ever had the same or similar illness? ☐ Yes ☐ No If 'Yes', state when and provide details

_____

_____

Did the illness result in an absence from work? ☐ Yes ☐ No If 'Yes', state when _____ (yy/mm/dd)

TREATMENT INFORMATION

Were you hospitalized? ☐ Yes ☐ No If 'Yes', Where _____ Admission Date _____ (yy/mm/dd) Discharge Date _____ (yy/mm/dd)

When did you first seek medical attention for this condition? _____ (yy/mm/dd)

Since your absence from work, what type of treatment have you received (eg. Medical, physiotherapy, counseling, etc.)?

_____

_____

TREATING PROVIDER INFORMATION **Please provide the following information about other health care practitioners involved in your treatment**

Last name____________________First name____________________Type of practitioner____________________

Address____
Street & Number City Province Postal Code

Telephone number____________________Frequency of visits________________Date of first visit__________Date of next visit__________
(yy/mm/dd) (yy/mm/dd)

Last name____________________First name____________________Type of practitioner____________________

Address____
Street & Number City Province Postal Code

Telephone number____________________Frequency of visits________________Date of first visit__________Date of next visit__________
(yy/mm/dd) (yy/mm/dd)

Last name____________________First name____________________Type of practitioner____________________

Address____
Street & Number City Province Postal Code

Telephone number____________________Frequency of visits________________Date of first visit__________Date of next visit__________
(yy/mm/dd) (yy/mm/dd)

Last name____________________First name____________________Type of practitioner____________________

Address____
Street & Number City Province Postal Code

Telephone number____________________Frequency of visits________________Date of first visit__________Date of next visit__________
(yy/mm/dd) (yy/mm/dd)

Last name____________________First name____________________Type of practitioner____________________

Address____
Street & Number City Province Postal Code

Telephone number____________________Frequency of visits________________Date of first visit__________Date of next visit__________
(yy/mm/dd) (yy/mm/dd)

Last name____________________First name____________________Type of practitioner____________________

Address____
Street & Number City Province Postal Code

Telephone number____________________Frequency of visits________________Date of first visit__________Date of next visit__________
(yy/mm/dd) (yy/mm/dd)

INCOME BENEFIT INFORMATION

Have you applied for, or are you currently receiving, any of the following benefits? (check all that apply)

Income/Benefit	Date of Application	Reference or claim number	Pending	Awarded	Declined	Terminated	Appealed
QPP/CPP/S.S.B.			☐	☐	☐	☐	☐
Other group insurance			☐	☐	☐	☐	☐
Association plan			☐	☐	☐	☐	☐
Auto			☐	☐	☐	☐	☐
Salary continuation			☐	☐	☐	☐	☐
Short-term plan			☐	☐	☐	☐	☐
EI			☐	☐	☐	☐	☐
Old Age Security			☐	☐	☐	☐	☐
Retirement			☐	☐	☐	☐	☐
Severance			☐	☐	☐	☐	☐
Veteran's allowance			☐	☐	☐	☐	☐
Social Services			☐	☐	☐	☐	☐
Creditor's disability insurance			☐	☐	☐	☐	☐
Employment			☐	☐	☐	☐	☐

SUMMARY OF EDUCATION

School Year	Location	Level Obtained	Area of Study

SUMMARY OF WORK EXPERIENCE

Please list your work experience over the past 15 years, starting with the most recent. If more space is required, please use an additional piece of paper.

Duration of employment (yy/mm/dd)

From	To	Employer	Job Duties

AQUIRED SKILLS

Please list any other acquired skills not previously mentioned, that you have (eg. Typing, operation of equipment, supervisory skills, special licenses, designations, etc.). Where appropriate indicate level, speed or proficiency.

LICENSE INFORMATION

Does your current occupation require you to hold a valid professional license or certifications? ☐ Yes ☐ No

If 'Yes', please list them, indicate any suspensions and the reason for the suspension.

_____

_____

WORK CAPACTIY EVALUATION

Physical Activities

Related to your occupation, to what extent are you able to perform the following activities? If you are requiring more space for an explanation, please use the 'Comment' section on page 8.

Activity	N/A	Infrequent (<2hrs)	Occasional (2-4hrs)	Frequent (4-6hrs)	Constant (>6hrs)	Unable to do	If 'Unable to do', please explain
Sitting	☐	☐	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	☐	☐	
Bending/Squatting	☐	☐	☐	☐	☐	☐	
Crouching	☐	☐	☐	☐	☐	☐	
Crawling	☐	☐	☐	☐	☐	☐	
Pushing	☐	☐	☐	☐	☐	☐	
Pulling	☐	☐	☐	☐	☐	☐	
Fine manipulation, fingers	☐	☐	☐	☐	☐	☐	
Simple grasping	☐	☐	☐	☐	☐	☐	
Repetitive body motions	☐	☐	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	☐	☐	
Reaching-above shoulder	☐	☐	☐	☐	☐	☐	
Reaching-at shoulder	☐	☐	☐	☐	☐	☐	
Reaching-side to side	☐	☐	☐	☐	☐	☐	
Reaching-up and down	☐	☐	☐	☐	☐	☐	

Lifting/Carrying

	N/A	0-10lbs	11-20lbs	21-50lbs	Infrequent	Frequent	Constant	Unable
Lifting-floor to waist	☐	☐	☐	☐	☐	☐	☐	☐
Lifting-wait to shoulder	☐	☐	☐	☐	☐	☐	☐	☐
Lifting-above shoulder	☐	☐	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐	☐	☐

Environment

Are you able to work in the following conditions?	Yes	No	If, 'No', explain
Exposure to extreme changes in temperature and humidity	☐	☐	_____
Around moving machinery or motorized equipment	☐	☐	_____
Below ground or elevated work areas	☐	☐	_____

WORK CAPACTIY EVALUATION continued

Responsibility and accountability

Are you able to work in a place or perform work that

Is without pressure to meet deadlines	☐ Yes	☐ No
Has occasional pressure to meet deadlines	☐ Yes	☐ No
Has frequent pressure to meet deadlines	☐ Yes	☐ No
Has constant pressure to meet deadlines	☐ Yes	☐ No

Psychological Activities

Relating to your occupation, to what extent are you limited from performing the following activities? If you require more space for an explanation, please use the 'Comment' section on page 8.

Activity	N/A	Unable to do	Severely Limited	Moderately Limited	Somewhat Limited	No Limitation
Remember locations and routine procedure	☐	☐	☐	☐	☐	☐
Understand and remember short and simple instruction	☐	☐	☐	☐	☐	☐
Understand and remember detailed instructions	☐	☐	☐	☐	☐	☐
Carry out simple instructions	☐	☐	☐	☐	☐	☐
Carry out detailed instructions	☐	☐	☐	☐	☐	☐
Maintain attention and concentration for extended periods	☐	☐	☐	☐	☐	☐
Perform activities within a schedule	☐	☐	☐	☐	☐	☐
Sustain an ordinary routine without supervision	☐	☐	☐	☐	☐	☐
Make simple decisions	☐	☐	☐	☐	☐	☐
Solve straightforward problems	☐	☐	☐	☐	☐	☐
Solve complex problems	☐	☐	☐	☐	☐	☐
Interact with the general public	☐	☐	☐	☐	☐	☐
Ask questions or request assistance	☐	☐	☐	☐	☐	☐
Accept instructions and feedback	☐	☐	☐	☐	☐	☐
Get along well with others without distracting them	☐	☐	☐	☐	☐	☐
Get along well with others without being distracted by them	☐	☐	☐	☐	☐	☐
Adapt to frequent changes in environment or tasks	☐	☐	☐	☐	☐	☐
Aware of normal hazards and take appropriate precautions	☐	☐	☐	☐	☐	☐
Travel in unfamiliar places or use public transportation	☐	☐	☐	☐	☐	☐
Set realistic goals or make plans independently of others	☐	☐	☐	☐	☐	☐
Prioritize and manage job tasks	☐	☐	☐	☐	☐	☐

INTERVIEW ARRANGEMENTS

As part of Wawanesa Life's claim management, we will be contacting you for a telephone interview about your claim. Please indicate your preferred time during the day to be contacted. (*Please note that it may be determined that a telephone interview is not required.*)

If a telephone interview is not possible, please explain why.

COMMENTS

Please provide any additional information or comments that you believe should be considered in assessing your claim.

IMPORTANT INFORMATION

I acknowledge I must notify Wawanesa Life immediately if:

a) My medical condition has improved or deteriorated
b) I perform any work, with or without pay
c) I apply for benefits under any plan of insurance related to my disability
d) I move or leave the country
e) I receive any other benefits or income related to my disability

Plan Member Signature

Authorizations and Declarations

AUTHORIZATIONS

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering my disability claim.

I also authorize my insurer, Wawanesa Life, or its reinsurers, to exchange the personal information obtained during my claim under this plan, with the insurer's reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

I understand that by furnishing this form and investigating the claim or by accepting Proofs of Claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the plan.

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; 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 understand that Wawanesa Life may share my personal information with the following people, organizations and service providers: Wawanesa Life employees who require this information to perform their jobs; claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies; people to whom I have granted access; and people who are legally authorized to view my personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions. I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the claim being applied for.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from www.wawanesalife.com or from our Customer Service Department, Wawanesa Life, 236 Carlton St, Winnipeg, MB R3C 1P5.
If you have a question (including a question concerning our collection of personal information or the collection, use, disclosure or storage of personal information by service providers outside Canada on our behalf) or complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance: Privacy Officer, The Wawanesa Life Insurance Company, 236 Carlton St, Winnipeg, Manitoba R3C 1P5.

DECLARATION AND SIGNATURE

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from Wawanesa Life and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended me and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting me for the purpose of administering my disability claim.

A photocopy or an electronic reproduction of this document will be as valid as the original.

WLI# _____

_____
Plan Member's Name (Print)

_____
(yy/mm/dd)

_____
Plan Member's Signature