



Notice of Claim To be completed by Distributor

Please print and complete all areas to avoid delay in processing claim

SECTION A – MEMBER INFORMATION

Member Name: _____ Date of Birth (dd/mm/yy): _____

Member Address: _____

Email: _____ Telephone No.: _____

SECTION B - CLAIM INFORMATION

Name of person who suffered loss: _____

Relation to Member? Same Spouse Dependent Child

If claim is for a Dependent, Spouse or Child: Name: _____ Date of Birth (dd/mm/yy): _____

Name of person reporting loss: _____ Telephone No.: _____

Relation to Member? Same Spouse Dependent Child Beneficiary Other: _____

SECTION C - NATURE OF CLAIM

Life Dependent Life Waiver of Premium Critical Illness Accidental Death or Dismemberment Long-term Disability

Date of Accident/Loss/Death: _____ (dd/mm/yy)

Country where Accident/Loss/Death occurred _____

For Long Term Disability – Last date worked: _____ (dd/mm/yy)

For Life, AD&D and CI - Beneficiary Name _____

Beneficiary email address and/or phone: _____

Claim Form(s) to be sent to (name): _____

via Email (email address): _____

or Mail (address): _____

**Please attach Beneficiary Form
and/or most recent change
form(s)**

SECTION D – ORGANIZATION INFORMATION

Distributor Name: _____ Telephone No.: _____

Contact Name: _____ Email: _____

ORGANIZATION:

Name of Policy Holder: _____ Group Certificate Number: _____

Name of Organization if Different from Policy Holder: _____

Policy No.: _____ Plan Effective Date (dd/mm/yy): _____ Premium paid to (dd/mm/yy): _____

Contact Name: _____ Title: _____

Address: _____

Telephone No.: _____ Fax: _____ Email: _____

PRIOR COVERAGE:

Was there similar coverage in place prior to this plan? Yes No If yes, prior carrier name: _____

Effective Date of prior coverage (dd/mm/yy): _____ Amount of Benefit under prior plan: _____

Termination Date of prior plan (dd/mm/yy): _____

MEMBER ADMINISTRATIVE DETAILS:

Date Member became eligible under plan (dd/mm/yy): _____

Position of Member: _____ Class / Division: _____

Coverage Option: _____ Premium paid to (dd/mm/yy): _____

Coverage Type (blanket, mandatory or optional): _____ Insured Amount: _____ NEM: _____

Was the insured underwritten for an optional or excess of N.E.M. benefit amount? Yes No

If yes to above, is there a Medically Underwritten Health Statement? Yes No

If no, provide details: _____

Have any changes been made to the Insured Person's coverage since the date of loss? Yes No

If yes, please provide details: _____

SECTION E (IF APPLICABLE)

TPA: _____

TPA Contact: _____ TPA Email: _____

DOCUMENTS REQUIRED TO SUBMIT TO WAWANESA LIFE CLAIMS DEPARTMENT

- Enrolment Form
- Subsequent-Change of Beneficiary Forms

**Please email Notice of Claim form and applicable supporting documents to:
WawanesaLife-Claims@wawanesa.com**

PERSONAL INFORMATION CONSENT

The information collected on this application for insurance is required for the purpose 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 Wawanesa Life Insurance 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 applicants may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

THE WAWANESA LIFE INSURANCE COMPANY

400 - 200 Main Street, Winnipeg, MB R3C 1A8

Tel: 1-844-318-0411, #3 Fax: 1-855-496-3028

WawanesaLife-Claims@wawanesa.com | wawanesalife.com