Western LIFE ASSURANCE

NOTE: THIS INSURANCE WILL NOT BE EFFECTIVE UNTIL APPROVED BY WESTERN LIFE

APPLICATION FOR EXCESS GROUP INSURANCE

1. EMPLOYEE'S NAME:

Age ____________ Date of birth M | D | Y

Occupation ____________

Do you have a regular or family physician? ❒ Yes ❒ No
If YES, provide details below. If NO, provide details of last doctor consulted.

Doctor: ____________

Address: ____________

Date last seen: M | D | Y

Reason for visit, treatment & results: ____________

2. POLICYHOLDER:

Benefits applied for:

❒ Life $

❒ Long Term Disability LTD $

❒ Weekly Income WI $

Has employee been covered by a Western Life group health plan or individual policy during the past 5 years? ❒ Yes ❒ No

Details: ____________

3. MEDICAL HISTORY	Yes	No	Provide details: duration, treatment, results, doctor/hospital
1. a. Height: ____________ Weight: ____________			
b. Weight one year ago: _______ lbs. **(If different, explain reason for change)**			
c. Have you been absent from work more than 7 consecutive days during the past 3 years because of illness or injury?	❒	❒	
2. Have you ever had, been told you had, or received treatment for any illness or disorder affecting the: **(Circle conditions which apply)**			
a. CARDIOVASCULAR SYSTEM such as: heart attack, stroke, angina or chest pain, high blood pressure, heart murmurs, irregular heart beat, blood clot, poor circulation or other disorder of the heart or blood vessels?	❒	❒	
b. RESPIRATORY SYSTEM such as: shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other disorder of lungs, nose or throat?	❒	❒	
c. NERVOUS SYSTEM AND SENSE ORGANS such as anxiety, dizziness, fainting, headaches, epilepsy or convulsions, multiple sclerosis, paralysis or stroke, nervous breakdown, burn out, depression, brain or spinal cord or disorder of skin, sight, hearing or other disorder of senses?	❒	❒	
d. DIGESTIVE SYSTEM such as: any disorder of the stomach intestines, rectum, liver, gallbladder, pancreas, hepatitis, indigestion, ulcer, hernia, colitis, diverticulitis or any bleeding of the stomach, intestines or rectum?	❒	❒	
e. URINARY AND REPRODUCTIVE SYSTEMS such as: sugar in urine or other abnormalities of urine, sexually transmitted disease, stones or other disorder of kidney, bladder, disorder of prostate or reproductive organs?	❒	❒	
f. GLANDULAR SYSTEM AND BLOOD such as: diabetes, thyroid, pituitary or other glands, high cholesterol levels, gout, enlarged glands, anemia, disorder of breasts, skin condition or allergy?	❒	❒	
g. MUSCULO-SKELETAL SYSTEM such as: arthritis, sciatica, rheumatism, rheumatic fever, back, spine or disc trouble, joint or bones or any other disorder of muscles, joints, neck or back?	❒	❒	
h. IMMUNE SYSTEM such as: AIDS, ARC (Aids Related Complex), chronic diarrhea, unusual skin lesions, multiple chronic unexplained infections?	❒	❒	

PLEASE DETACH AND KEEP THIS NOTICE

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Western Life Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will also arrange disclosure of any information in your file. (Medical information will be disclosed only to your attending physician).

If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB information office is:

MIB Information Office
330 University Avenue, Suite 501
Toronto, Ontario, M5G 1R7
Telephone Number: (416) 597-0590

Western Life Assurance Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICAL HISTORY continued (circle conditions which apply)	Yes	No	Provide details: duration, treatment, results, doctor/hospital
3. Have you:			
a. Ever been advised to follow a special diet or undergo treatment for any condition or are you presently taking any medication (including herbal)? If yes, advise name of medication.	☐	☐	
b. Ever had or been told you have a cyst, tumour, leukemia, cancer or unusual growth in any part of the body?	☐	☐	
c. Ever had test results indicating exposure to the AIDS virus, or received any related medical advice or treatments?	☐	☐	
d. Ever used drugs such as heroin, cocaine, LSD, barbiturates, amphetamines, marijuana, or other hallucinogenic, narcotic, or addictive drugs or other drugs except as prescribed by a physician?	☐	☐	
e. Ever received advice, counselling or treatment, or belonged to an organization because of the use of alcohol or drugs?	☐	☐	
f. Ever been declined, rated, modified or postponed for life or health insurance or had any health insurance policy cancelled or non-renewed? If Yes, give companies, dates and reasons for such action.	☐	☐	
4. a. In the past 5 years, except as mentioned, had an electrocardiogram, x-ray or other diagnostic test or been advised to have any investigation, hospitalization or surgery, which has not been completed?	☐	☐	
b. In the past 5 years, except as mentioned, consulted a doctor or chiropractor for any reason or been a patient in a hospital?	☐	☐	
c. Do you drink alcoholic beverages? If Yes, indicate average weekly amount.	☐	☐	
d. In your immediate family, any history of high blood pressure, stroke, heart or kidney disease, diabetes, mental or nervous disorder, or suicide?	☐	☐	
e. If applicable, had any menstrual disturbance or complicated pregnancy?	☐	☐	
Are you pregnant? If yes, date of expected delivery? ____________	☐	☐	

4. DECLARATION AND AUTHORIZATION

I declare that all the information shown above and on the reverse side of this application is 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 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 authorize any physician or health care professional, hospital or other medically related facility and the MIB, Inc., formerly known as 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.

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.

Date ____________ Signature of Applicant ______________________________ 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

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THIS STUB MUST BE DETACHED AND RETAINED BY THE EMPLOYEE

CHECKLIST

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 application.

- All questions must be answered in ink.
- Any changes or errors must be initialled by the employee and witnessed. **Do not use white-out**. (This is a legal document.)
- 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.