

Please choose one of the following two payment options.

Option 1 – Pre-Authorized Debit – Attach Cheque Marked ‘VOID’

Account Owner Full Name(s) _____

Phone No. _____

Address _____

Email Address _____

Financial Institution (F.I.) _____

Branch Address _____

Type of Account (must allow electronic debits): Savings Chequing

Transit No. _____

F.I. No. _____

Account No. _____

Please select the day of the month the payment is to be drawn from the account: _____

PAD DETAILS – You, the Payor, authorize Wawanesa Life Insurance Company to debit the bank account identified above for the amount(s), frequency and on withdrawal day indicated or the next business day.

POLICY NUMBER	AMOUNT	NAME OF POLICY OWNER OR PROPOSED LIFE INSURED

OPTION 2 – CREDIT CARD – Only available on select products and annual premium payment

When CHANGING OR UPDATING credit card information for an inforce policy the card holder must be the one to contact our office directly via telephone at 1-800-263-6785 OR complete a new PAYMENT OPTION FORM, signed by the client that MUST be MAILED/COURIERED to our office. We cannot accept this form by email or fax.

The Wawanesa Life Insurance Company is authorized to charge my Credit Card. I agree to furnish The Wawanesa Life Insurance Company with the updated Credit Card Expiry date as required. This authorization extends to any replacement cards I may receive and will remain in effect until I cancel it.

Card Type: MASTERCARD VISA *Amex, Debit or Prepaid Cards are not accepted.*

Card Number (only provide if mailing form) _____

Expiry Date (only provide if mailing form)

Name as it appears on the Credit Card

Cardholder Address

City

Province

Postal Code

Telephone

Authorization And Signature

Credit Card:

- Regular ANNUAL payment in the amount of \$_____ will be charged to the credit card
on _____ of each year.
MM/DD

Pre-Authorized Debit:

- Regular MONTHLY payment in the amount of \$_____ will be debited to my/our account
on the _____ day of each month.
MM/DD
- Regular ANNUAL payment in the amount of \$_____ will be debited to my/our account
on the _____ day of each year.
MM/DD

I understand that premiums may increase by the amount required to keep my policy in effect as stated in my policy.
I agree that this authorization in no way affects the terms or conditions of the policy.

The Wawanesa Life Insurance Company is authorized to draw cheques under its Pre-Authorized Payment Plan (PAPP) on the Account and Financial Institution designated by me. I further authorize such institution and any of its branches to deal with such transfers as though they were signed by me.

- 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.
- I also agree to furnish The Wawanesa Life Insurance Company with a voided blank cheque now and at any future time, as required, to assure the accurate imprinting of bank information on my Pre-Authorized transfers.
- I may revoke my authorization at any time, subject to providing notice of 10 days' notice. To obtain a sample cancellation form, or for more information on my right to cancel a PAPP Agreement, I may contact my financial institution or visit www.cdnpay.ca
- Every effort will be taken to meet the same date every month, however this date could change for a given month.
- Wawanesa Life is not required to provide notification before the initial premium is debited.
- I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAPP agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca

This authorization shall continue in force so long as said policy shall qualify for premium payments under this plan or until this authorization is revoked. Either party to this agreement may terminate this authorization by written notice mailed to the other party at his address of record.

Signature of Bank Account Holder / Credit Cardholder

Dated _____
Date (mm/dd/yyyy)

Signature of Bank Account Holder / Credit Cardholder

Dated _____
Date (mm/dd/yyyy)

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 The 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 applicant 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.

Please return form to wawanesa life.

Email: lifeservices@wawanesa.com

Fax: 1-888-985-3872

Mail: 400-200 Main St, Winnipeg MB R3C 1A8

Tel: 1-800-263-6785

wawanesalife.com