Manulife Financial

Group Benefits
Plan member/Dependant Enrolment/Change

Please print clearly, complete all pages and ensure form is signed. Mandatory fields (*) must be completed.

Plan sponsor name	Completed by (Print)	Title	Completed by (Signature)	Date (dd/mmm/yyyy)

1 Plan member information

To be completed by plan sponsor

Plan contract number *	Plan member certificate number (maximum of 9 characters) *

Plan sponsor name	Class	Division	Plan member occupation

Plan member's name (last, first, middle initial)

Address

City	Province	Postal code

All changes must be submitted within 31 days from the effective date of the change, or Manulife Financial will require evidence of insurability.

Effective date of change (dd/mmm/yyyy)	Coverage code(s)	Distribution code

Date of hire (dd/mmm/yyyy)	Sex ○ Male ○ Female	Date of birth (dd/mmm/yyyy)	Language ○ English ○ French	Hours worked per week

Type of change - Check (✓)

○ Add new member ○ Terminate benefit(s) ○ Change ○ Single ○ Family

○ Reinstate† ○ Add benefit(s) ○ Transfer from _____ to _____

○ Student ○ Late entrant dependant ○ Left employment on (dd/mmm/yyyy) _____

† Please indicate reason for reinstatement (mandatory) on separate page

Change of plan member certificate number (maximum of 9 characters)	Transfer to plan contract number	To coverage code(s)

If applying for coverage due to loss of coverage under spouse's plan, please provide date coverage terminated:	(dd/mmm/yyyy)

Marital status	Retired (dd/mmm/yyyy)

Deceased (dd/mmm/yyyy)	Other (please specify)

	Add	Delete		Add	Delete
Health	○	○	Travel	○	○
Dental	○	○	Hospital	○	○
Prescription Drugs	○	○	Vision	○	○
Life	○	○	Long term disability	○	○
Dependant Life	○	○	Critical illness	○	○
AD&D	○	○	Managed dental care	○	○
Weekly Indemnity	○	○	Dental centre number _____		

Complete for Life and Income Replacement Benefits

Earnings	
$	○ Annual ○ Monthly ○ Weekly

1 Plan member information (continued)

Optional coverages	◯ Add ◯ Change ◯ Delete	
Life (state total amt.)	Plan member $	Spouse $
AD&D (state total amt.)	◯ Single ◯ Family	$
Dependant life	◯ Yes ◯ No	
Critical illness	Plan member amount $	Spouse amount $

Smoker ◯ Yes ◯ No | Plan member ◯ Yes ◯ No | Spouse ◯ Yes ◯ No

(Non-smoker is someone who has not smoked or used tobacco in any form during the preceding 12 months.)

RAMQ - If you are a resident of Quebec and 65 years of age or older, are you covered under RAMQ?
◯ Yes (Manulife Financial is second payer)
◯ No (Manulife Financial is first payer)

2 Dependant information

To be completed by plan member only if family coverage has been elected.

If application to add dependant coverage is not made within 31 days of marriage, birth/adoption of a child, or the date of loss of spousal coverage, evidence of insurability of the dependant(s) will be required.

For common-law status, the couple must have been cohabiting as defined by the plan contract provisions for dependant eligibility.

Type of change A/C/T	Relationship	Last name (if different)	First name	Middle initial	Sex (M/F)	Date of birth (dd/mmm/yyyy)	Dependant status G/C	Effective date (dd/mmm/yyyy)
	Spouse**				◯ M ◯ F			
	Child				◯ M ◯ F			
	Child				◯ M ◯ F			
	Child				◯ M ◯ F			
	Child				◯ M ◯ F			

Type of change: **A** = Add, **C** = Change, **T** = Terminate

Dependant status codes: **G** = Student (College/University), **C** = Disabled

** If common-law spouse, please state the date of commencement of cohabitation (dd/mmm/yyyy)

School year

Co-ordination of benefits

If you do not have a spouse, this section does not apply.

Spousal Health Coverage Does your spouse have health coverage under his/her own insurance plan? ◯ Yes ◯ No — Effective date (dd/mmm/yyyy)

Spousal Dental Coverage Does your spouse have dental coverage under his/her own insurance plan? ◯ Yes ◯ No — Effective date (dd/mmm/yyyy)

Does your spouse's health/dental plan cover:

Health	Dental	Hospital	Prescription Drugs	Vision	
◯	◯	◯	◯	◯	Your spouse only
◯	◯	◯	◯	◯	Your spouse and yourself only
◯	◯	◯	◯	◯	Your spouse and children only
◯	◯	◯	◯	◯	Your spouse, you and your children

Spouse's date of birth (dd/mmm/yyyy)

3 Change of beneficiary

If more space is required, please complete a second form and attach.

Percentages must total 100% to be valid.

In accordance with the terms and conditions of the Group Life Contract between the plan sponsor indicated below and Manulife Financial, I revoke all previous appointments of beneficiary and hereby appoint the following as beneficiary entitled to receive the proceeds arising by reason of my death.

Beneficiary's last name	First name	Middle initial	Relationship	Percentage
				%
				%
				%
				%

3 Change of beneficiary (continued)

Under the laws of the Province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.

◯ I hereby declare and stipulate that the beneficiary designations made on this form are revocable.

Note: If you designate a minor child as the beneficiary of your insurance proceeds, these proceeds will be paid into court, unless a trustee is appointed to receive such benefits on behalf of such child.

Trustee appointment (you may wish to consult a lawyer before appointing a Trustee).

Complete if the beneficiary is under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

Proceeds payable to a minor in Quebec will be paid out in accordance with the provisions of the Quebec Civil code. The appointment of a Trustee is not applicable in Quebec. You may wish to consult a lawyer before appointing a minor beneficiary.

4 Status change

When a plan member requests a change from single to family coverage within 31 days of marriage, or 31 days of loss of coverage under your spouse's plan, family coverage will become effective as outlined in the Manulife Financial group benefits contract. If applying after more than 31 days a statement of health satisfactory to Manulife Financial will be required.

Date of change in marital status or loss of spousal coverage

(dd/mmm/yyyy)

If spouse currently has Manulife Financial benefits, please complete

Plan contract number	Plan member certificate number	Last name

5 Waiver of Benefits

(To be completed and signed by plan member - If not applying for coverage)

I have been given the opportunity to apply for coverage but do not wish to participate. I understand that if I wish to request coverage at a later date, I will be required to furnish, at my own expense, for myself (and if applicable, for my eligible dependant(s)) evidence of insurability satisfactory to Manulife Financial. For Dental coverage, benefits will be limited during the first 12 months of coverage.

I wish to waive the following benefit(s): ◯ Health ◯ Dental

6 Authorization

To be signed by plan member

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("Manulife"). **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I designate** the person(s) named above under Beneficiary Designation, as my beneficiary.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan member's signature	Date signed (dd/mmm/yyyy)

Plan Member Administration
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1

1-866-769-5556

Website: www.manulife.ca/groupbenefits/secureserve