Manulife Financial

For your future™

Group Benefits – *e*-Enrolment or Re-enrolment Application

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

1 Plan sponsor statement

To be completed and signed by plan sponsor.

Enter member's certificate number, if known. Otherwise leave blank for Manulife Financial to complete.

Plan contract number	Account/Division number	Billing division (if applicable)	Plan member certificate number

Plan sponsor name	Plan sponsor telephone number

Provide **permanent** full time hire date (dd/mmm/yyyy)	If a re-hire, provide the date previous employment ended (dd/mmm/yyyy)	Re-hire date (dd/mmm/yyyy)

Do you want the waiting period added to the permanent full time hire date? ◯ Yes ◯ No

Plan member's occupation	Class	Regular hrs./week	Annual earnings
			$

I certify that the **plan member** listed below is **actively at work** at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature	Date signed (dd/mmm/yyyy)

In order to determine if evidence of insurability is required, please refer to your contract.

Is evidence of insurability required? ◯ Yes ◯ No

If evidence of insurability is required, plan members must complete GL0004E, *Evidence of Insurability*, and send it to Manulife Financial for processing. **Manulife Financial will not contact your Plan Administrator to verify that this form has been mailed.**

2 Plan member information

We require this information to enrol you in the plan.

Plan member name (last, first, middle initial) (please print)	Date of birth (dd/mmm/yyyy)

Sex	Province of residence	Language of preference
◯ Male ◯ Female		◯ English ◯ French

3 Plan member address

Address (number, street, apt. number)		
City	**Province**	**Postal code**

4 Applying for coverage

Note: You may refuse benefits for yourself and your dependant(s)/ spouse ONLY if you are covered for similar benefits under your spouse's plan. If you wish to add this coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

Applying for Health and Dental Benefits

Health	Dental	
◯	◯	Myself ONLY
◯	◯	Myself AND 1 dependant/spouse
◯	◯	Myself and 2 or more dependants/spouse
◯	◯	None, because my spouse has coverage

Dependant Life

◯ Yes ◯ No

Note: If you have eligible dependants, refusal of this benefit is not allowed on an AlphaPlus plan.

Do you have a common-law spouse? ◯ Yes ◯ No

If common-law spouse, provide the date the co-habitation commenced. Date (dd/mmm/yyyy)

5 Coordination of benefits

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

This information is important for the correct adjudication of your claims.

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	
◯	◯	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)

6 For Quebec residents (age 65 or over)

◯ I am participating in the RAMQ drug plan provided by the Quebec government
◯ I am NOT participating in the RAMQ drug plan provided by the Quebec government

7 Family information

*Complete this section **only** if you are required to enrol your spouse and/or dependants.*

If more than 4 children, please attach a separate listing.

If requesting family coverage, please ensure your spouse and children are listed below, regardless of whether they have health or dental care coverage under another plan.

Spouse/child name Include last name if different from your last name (last, first, middle initial)	**Date of birth** (dd/mmm/yyyy)	**Sex** (M or F)	**Relationship code H/W/S/C** (see below)	**Full-time student?** (Yes or No)
spouse		◯ M ◯ F		N/A
child		◯ M ◯ F		◯ Yes ◯ No
child		◯ M ◯ F		◯ Yes ◯ No
child		◯ M ◯ F		◯ Yes ◯ No
child		◯ M ◯ F		◯ Yes ◯ No

Relationship codes: **H** = Husband, **W** = Wife, **S** = Common-law spouse, **C** = Child

If a dependant is disabled and over-age, please complete GL0514E, *Application for Over-Age Disabled Dependant Coverage*.

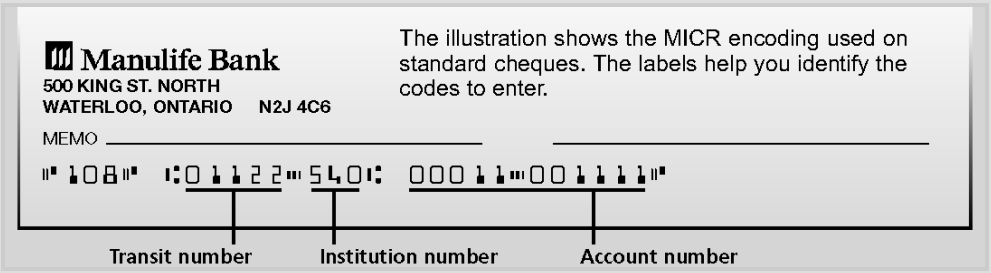
8 Beneficiary designation

For benefits payable upon death, the beneficiary will be ESTATE. If you would like to designate a named beneficiary other than "ESTATE", please complete and sign GL1435E, *Beneficiary Designation.*

9a Direct deposit

Complete the following section if you would like to sign up for direct deposit of your claim payments.

Name of financial institution			
Address (number, street)	City	Province	Postal code
Transit number (5 digits)	Institution number	Bank account number	



9b Electronic claim statement

By completing the email section, you will be sent an invitation to register for an online member account.

Complete the following section only if your plan offers online services and you wish to enroll for the service.

If the email and banking fields are completed you will receive an electronic claim statement, otherwise you will receive your claim statement by mail.

Email

10 Plan member signature

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.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative. **I understand and agree** that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

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.

Please sign and date here.

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

11 Mailing instructions

Please send the completed form to:

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

La version française du document se trouve à l'adresse www.manuvie.com/assurancecollective.