Manulife Financial

Group Benefits
Enrolment or Re-enrolment Application

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

Please send the completed form to:
Manulife Financial, Group Benefits, Plan Member Administration, PO BOX 1627, WATERLOO ON N2J 4P4

1 Plan Sponsor statement

Enter your certificate number if known. Otherwise leave blank for Manulife Financial to complete.

Plan number	Account/Division number	Billing division (if applicable)	Certificate number

Plan Sponsor name

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)

Does the waiting period apply to this application? ◯ Yes ◯ No

Plan member's occupation	Class

Regular hrs./week	Annual earnings
	$

Is evidence of insurability required? ◯ Yes ◯ No

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

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 to be completed ONLY for Deferred Payment Drug Plans.

Address (number, street, apt. number)

City	Province	Postal code

4 Applying for coverage

Note: You may refuse benefits for yourself and your dependent(s) ONLY if you are covered for similar benefits under your spouse's plan. You may apply at a later date for benefits you have refused. Certain conditions will apply. *Please see your Plan Administrator for details.*

Applying for Health and Dental Benefits

Health	Dental	
◯	◯	Myself ONLY
◯	◯	Myself AND 1 dependent
◯	◯	Myself and 2 or more dependents
◯	◯	None, because my spouse has coverage

Dependent Life
◯ Yes ◯ No

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

5 Coordination 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 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)

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

If common-law spouse, provide the date the co-habitation commenced. Date (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 dependents.*

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)	**Disabled dependent?** (Yes or No)
spouse		◯ M ◯ F		N/A	N/A
child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No

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

If a dependent is disabled, please complete GL0514E, *Request for Over-Age Dependent Coverage/Termination of Over-Age Dependent Coverage.*

8 Beneficiary designation

If a beneficiary is not assigned, "ESTATE" will be assumed.

Name of beneficiary (last, first, middle initial)	Relationship to member
Name of beneficiary (last, first, middle initial)	Relationship to member
Name of beneficiary (last, first, middle initial)	Relationship to member

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 18. If the plan member is a Quebec resident, it is assumed a Trust agreement has been drawn up.

Irrevocability

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

9 Plan member signature

I designate the person(s) named above under Beneficiary Designation as my beneficiary.
I certify that the information in this form is true and complete, to the best of my knowledge.
If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purposes of determining their eligibility for benefits.
If my Social Insurance Number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.
If applicable, I authorize my plan sponsor to make deductions from my pay for my group benefits.

Please sign and date here.

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

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:
- our employees, service representatives, and reinsurers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, if necessary, correct any inaccurate information.

For Manulife Financial use only

Multiple Group No.	Effective date of Insurance dd/mmm/yyyy	CLASS	MODE	SAL	LIFE	A D & D	WI	LTD	EHC	DEN	DEP. LIFE	OCC	DIV	COB	DRUG PLAN	LATE EE	LATE DEP	MNL	CII EVA
Multi Accts														Cov Indicator		Expiry date		Tax Exempt	
EXCESS									HCSA		SENT NOTE							Initials	

Ce document est aussi disponible en français sur demande (GL2971F).