Manulife Financial

LIFE
A BENEFIT PLAN FOR FIRST NATIONS

Group Benefits Enrolment Application (Please indicate if re-enrolment ◯)

Please complete both pages of form. If required, retain a photocopy for your files.
Send completed form to: Plan Member Administration, Manulife Financial, PO BOX 2026, HALIFAX NS B3J 2Z1

1 Plan sponsor/Employer statement

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

FOR OFFICE USE - Class legend:
Class A - Status Employee (and status dependant(s) if employee is family)
Class B – Non-Status Employee (and non-status dependant(s) if employee is family)
Class C – Status Employee with non-status dependant(s)
Class D – Non-Status Employee with status dependant(s).

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

Contract/group number	Account number	Billing division	Class	Certificate number/plan member ID

Plan sponsor name/Employer	Plan administrator name

Telephone number	Email address

Employment date (dd/mmm/yyyy)	Re-hire date (dd/mmm/yyyy)	If a re-hire, provide the date previous employment ended (dd/mmm/yyyy)

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

Plan member's occupation	For office use Class (see legend)

Regular hrs./week	Annual earnings
	$

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)	Date of birth (dd/mmm/yyyy)

Sex	Province of residence	Status/Non Status	Language of preference
◯ Male ◯ Female			◯ English ◯ French

3 Plan member address

Address (number, street, apt.)		

City	Province	Postal code

4 Applying for coverage

Note: You may refuse benefits for yourself and your dependant(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 (Please refer to your Plan Administrator if you and your spouse both work for this employer and you have eligible dependants.)

Health	Dental	
◯	◯	Single
◯	◯	Family
◯	◯	Waive, because my spouse has coverage

Dependant Life

◯ Yes ◯ No **Note:** If you have a spouse or eligible dependants, you must select yes.

5 Co-ordination of benefits

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

*Government sponsored plans are not subject to co-ordination of benefits.

Spouse's Health Coverage Does your spouse have health coverage at his/her place of work?* ◯ Yes ◯ No

Spouse's Dental Coverage Does your spouse have dental coverage at his/her place of work?* ◯ Yes ◯ No

If yes, is the coverage single or family?

Health	Dental		Spouse's date of birth (dd/mmm/yyyy)
◯	◯	Single	
◯	◯	Family	

Effective date of coverage (dd/mmm/yyyy)

6 Family information

To ensure proper Dependant Life coverage, please list below your spouse and children regardless of whether they have health or dental care coverage under another plan.

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

Spouse/child name Include last name if different from your last name (last, first, middle initial)	Status/ Non-Status (S, N/S)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Full-time student? (Yes or No)	Disabled dependant? (Yes or No)	For office use – Class
spouse				N/A	N/A	
child					◯ Yes ◯ No	
child					◯ Yes ◯ No	
child					◯ Yes ◯ No	
child					◯ Yes ◯ No	

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

7 Beneficiary designation

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

If more than four beneficiaries, attached a separate listing.

Name of beneficiary (last, first, middle initial)	Relationship to member	Minor beneficiary?	Percent must equal 100%
		◯ Yes ◯ No	
		◯ Yes ◯ No	
		◯ Yes ◯ No	
		◯ Yes ◯ No	

Complete if the beneficiary is under the age of majority.

I appoint _____ , my _____ ,
(indicate relationship)
as Trustee to receive any amount due to any beneficiary under the age of majority.
(If the employee is a Quebec Resident, ensure a trust agreement is drawn up.)

8 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. **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:

- Life Benefit Solutions Inc.
- 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.

Print

Please sign and date here.

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

Ce document est aussi disponible en français sur demande (GL4126F).