Manulife Financial

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 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
	$

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)	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.

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)

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 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

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

Percentages must total 100% to be valid.

Complete if the beneficiary is under the age of majority.

Name of beneficiary (last, first and middle initial)	Relationship to plan member	Percentage of benefit
		%
		%
		%

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

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 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.

Print

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)

10 Mailing instructions

Please send the completed form to:

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

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	

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