Manulife Financial

Group Benefits
Application for Optional Life Insurance for Plan Member and Dependants

INSTRUCTIONS - Please print all answers

1. *Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box to indicate the type of coverage for which you are applying.*
   ◯ *PLAN MEMBER ONLY* ◯ *PLAN MEMBER AND SPOUSE* ◯ *PLAN MEMBER, SPOUSE AND DEPENDANTS* ◯ *SPOUSE AND/OR DEPENDANTS*
2. *Please ensure that ALL SECTIONS are completed.*
   *Section 1 - Plan sponsor's information - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR**.*
   Sections 2, 3, 4, 5 and 6 - Plan member's information - To be completed by plan member and submitted to Manulife Financial.
3. *This application **MUST BE** submitted to Manulife Financial with a **COMPLETED** Evidence of Insurability form (GL0004E). (Evidence of Insurability is **NOT** required if changing status from "Smoker" to "Non-smoker".)*
4. ***If required, retain a photocopy for your files.***

1 Plan sponsor's information

Plan contract number(s)	Division number	Plan member certificate number	
50231	010		
		Class	**Annual earnings** $
Plan sponsor: Saint Mary's University			Eligibility date (dd/mmm/yyyy)

Optional life amount:

Plan member's present amount of optional life	$ ____	OR ___	units of	$ ____	OR ___	x salary	$ ____	=	$ ____
Additional amount requested	$ ____	OR ___	units of	$ ____	OR ___	x salary	$ ____	=	$ ____
Total amount requested	$ ____	OR ___	units of	$ ____	OR ___	x salary	$ ____	=	$ ____

Spousal optional life amount:

Spouse's present amount of optional life	$ ____	OR ___	units of	$ ____	OR ___	x salary	$ ____	=	$ ____
Additional amount requested	$ ____	OR ___	units of	$ ____	OR ___	x salary	$ ____	=	$ ____
Total amount requested	$ ____	OR ___	units of	$ ____	OR ___	x salary	$ ____	=	$ ____

Dependant optional life amount:

Dependant's present amount of optional life	$ ____	OR ___	units of	$ ____
Additional amount requested	$ ____	OR ___	units of	$ ____
Total amount requested	$ ____	OR ___	units of	$ ____

Plan administrator name	Date signed (dd/mmm/yyyy)
Phone number	Email address

2 Plan member's information

Plan member's name (last, first and middle initial)		Date of birth (dd/mmm/yyyy)
Language preference/Langue préférée ◯ English/Anglais ◯ French/Français	Sex ◯ Male ◯ Female	Province of residence

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

Please complete both pages of this form.

3 Beneficiary designation information

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

Name of beneficiary (last, first and middle initial)	Relationship to plan member
Additional name, if applicable (last, first and middle initial)	Relationship to plan member
Additional name, if applicable (last, first and middle initial)	Relationship to plan member

For designated beneficiaries under the age 18.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.

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.**

4 Spousal coverage

Note: you will be the beneficiary of your spouse's insurance, if you are then living, otherwise the beneficiary will be your estate.

Spouse's name (last, first and middle initial)	Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)

Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

5 Dependant coverage

Note: you will be the beneficiary of your dependant's insurance, if you are then living, otherwise the beneficiary will be your estate.

Dependant's name (last, first and middle initial)	Date of birth (dd/mmm/yyyy)
Relationship to plan member	Student status full time student ◯ Yes ◯ No

6 Plan member's information

Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **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 understand** that any Coverage shall not become effective until approved by Manulife. **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 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 (dd/mmm/yyyy)
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date (dd/mmm/yyyy)

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 your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

7 Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1