Manulife Financial

Group Benefits
Application for Change

Please print clearly and complete all pages of form.
Please complete SECTIONS 1 & 8 for ALL changes and any other sections that are applicable to your change.
If required, retain a photocopy for your files.

1 General information

We require this information to process your request.

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

Plan administrator name	Plan administrator telephone number ( )

Plan member name (last, first, middle initial)

2 Plan member name change

New name (last, first, middle initial)

3 Plan member address

Address (number, street, apt. number)

City	Province	Postal code

4 Addition or deletion of benefits

A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.

You may refuse Extended Health Care and or Dental Care for yourself and/or your dependant(s) only if covered for similar benefits under spouse's plan.

If you wish to add coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

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

Health and Dental Benefits

◯ **Addition**

Health	Dental	
◯	◯	Myself ONLY
◯	◯	Myself AND 1 dependant
◯	◯	Myself and 2 or more dependants
◯	◯	My dependants ONLY (I am already covered)

◯ **Deletion**

- ◯ Refuse Extended Health Care
- ◯ Refuse Dental Care
- ◯ Terminate coverage for all dependant(s)
- ◯ Terminate coverage for specific dependant(s) (see section 6)

Dependant Life ◯ I wish to add Dependant Life Insurance ◯ I wish to delete Dependant Life Insurance

Reason for addition	Effective date (dd/mmm/yyyy)	Reason for deletion	Effective date (dd/mmm/yyyy)
◯ Marriage		◯ Divorce	
◯ Common-law relationship		◯ Separation	
◯ Spouse's coverage cancelled		◯ Coverage with spouse	
◯ Other		◯ Other	

Please give details of "Other"

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.**

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

5 Co-ordination of benefits

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

Complete sections 5 and 6 only if you are required to enrol your spouse and children, and you need to change information.

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 Family information

Complete this section only when you are changing information pertaining to dependants that have previously been enrolled OR when you are adding/deleting a dependant. If more than 4 children, please attach a separate listing.

Change type code A/D/C (see below)	Effective date of change (dd/mmm/yyyy)	Spouse/child 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

Change type codes: **A** = Add, **C** = Change, **D** = Delete **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.

Over-age dependant(s) who is/are full-time student(s)

Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the next school year, the upper limit of the dependant definition age, or until coverage is terminated.

Name of student #1 (last, first, middle initial)

Name of accredited school/college/university	Location of school/college/university
Date school year: Begins (dd/mmm/yyyy)	Ends (dd/mmm/yyyy)

Name of student #2 (last, first, middle initial)

Name of accredited school/college/university	Location of school/college/university
Date school year: Begins (dd/mmm/yyyy)	Ends (dd/mmm/yyyy)

Termination of over-age student coverage

This only applies if you have over-age dependant children who are no longer students.

◯ I wish to terminate ALL coverage for DEPENDANT NAME

Effective date of termination (dd/mmm/yyyy)

Reason for termination

7 Beneficiary change

◯ Change of name only
◯ Change of beneficiary

Percentages must total 100% to be valid.

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

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 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.**

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 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.

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)

9 Mailing instructions

Return to your plan administrator.

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	