Manulife

Group Benefits
Enrolment or Re-enrolment Application

- Section 1 is to be completed by the plan administrator
- The remaining sections are to be completed by the plan member
- Please print clearly in dark ink using CAPITAL LETTERS.

1 Plan sponsor statement

Plan sponsor name Ed Mirvish Enterprises Limited Plan contract number 613629

Account/Location number 001 Billing division _____ Plan member's certificate number _____

Permanent hire date (dd/mmm/yyyy) _____ Do you want to waive the waiting period? ◯ Yes ◯ No

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

Class/Plan _____ Occupation _____

Hours worked/week _____ Salary $ _____ Frequency _____

I certify that the **plan member** listed below is **actively at work** at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature _____ Date (dd/mmm/yyyy) _____

Registered under the Canadian *Indian Act* for provincial tax exemption purposes? ◯ Yes ◯ No

Is evidence of insurability required? ◯ Yes ◯ No (in order to determine if evidence of insurability is required, please refer to your contract.)

If *yes*, please complete form GL0004E and send to Manulife for processing.

Health Care Spending Account (HCSA)

◯ Yes HCSA plan number _____ HCSA effective date (dd/mmm/yyyy) _____

◯ No Allocation amount $ _____

2 Plan member information

To be completed by employee

Plan member's last name _____ First name _____

Date of birth (dd/mmm/yyyy) _____ Sex* ◯ Male ◯ Female ◯ Non-binary

Province of residence _____ Language ◯ English ◯ French

Do you have a spouse? (married, common law or civil union?) ◯ Yes ◯ No

*Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

3 Plan member address

Address (number, street, apt.) _____

City _____ Province _____ Postal code _____

4 For Quebec residents

(age 65 or over) Are you participating in the RAMQ drug plan? ◯ Yes ◯ No

5 Application for coverage

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

I am applying for Extended Health Care for

- ◯ Myself only
- ◯ Myself and 1 dependant (child or spouse)
- ◯ Myself and 2 or more dependants (spouse and children)
- ◯ None, because my spouse has coverage

I am applying for Dental Care for

- ◯ Myself only
- ◯ Myself and 1 dependant (child or spouse)
- ◯ Myself and 2 or more dependants (spouse and children)
- ◯ None, because my spouse has coverage

Are you applying for Dependant Life? ◯ Yes ◯ No

Dependant Life may be mandatory.
Refer to the policy details.

6 Coordination of benefits

This section is required if you are applying for coverage on your dependants.

Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? ◯ Yes ◯ No

If *yes*, please provide the following details: Name of other insurer _____

Insured's last name _____ First name _____

Date of birth (dd/mmm/yyyy) _____ Effective date of coverage (dd/mmm/yyyy) _____

Identification/certificate number _____ Policy number _____

Please indicate type of coverage under other plan:

In cases where the information is not complete, a default value of Secondary will be applied.

Extended Health Benefits	Dental Care
◯ Single	◯ Single
◯ Couple	◯ Couple
◯ Family	◯ Family
◯ None	◯ None

7 Dependant information Spouse

If there is not enough room to list your dependants, attach details on a separate sheet.

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5 Application for coverage.

Last name _____ First name _____

Date of birth (dd/mmm/yyyy) _____ Sex* ◯ Male ◯ Female ◯ Non-binary

If common law, please provide the effective date of cohabitation (dd/mmm/yyyy) _____

Last name	First name	Date of birth (dd/mmm/yyyy)	Sex* Male	Female	Non-binary	Over-age student	Over-age disabled dependant**
			◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯

*Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

**To apply for over-age disabled dependant coverage, please complete form GL0514E.

8 Banking information and email address

Complete **only** when providing new or updated information.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.

By providing your email address, you will receive an invitation to register for your Plan Member secure site where you can view your electronic claim statements.

Email address (Please print clearly)

9 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by 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.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Centre.

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/planmember, or from my Plan Sponsor.

PLEASE SIGN HERE

Signature of plan member _____ Date signed (dd/mmm/yyyy) _____

10 Mailing instructions

Plan Member Administration
Manulife
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8

PRINT RESET