III Manulife

Group Benefits Enrolment or Re-enrolment Application

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

_									
1	Plan sponsor statement	Plan sponsor name Eddie Baue	r of Canada Corporation	<u>ו</u> PI	an contract number <u>614730</u>				
		Account/Location number 001	Billing division	Plan m	ember'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)							
		Class/Plan Occupation	Hou	s worked/week	Salary \$	Frequency			
		nember listed below is actively at we e of at least the set minimum hours p	ork at their usual place of em	ployment in Canad	a. Actively at work means the pl	lan member works			
		Plan administrator signature			Date (dd/mmm/yyyy)				
		Registered under the Canadian Indi	◯ Yes ◯ No						
		Is evidence of insurability required?		order to determine i r contract.)	f evidence of insurability is require	ed, please refer to			
		If yes, please complete form GL000		•					
	ealth Care			CSA effective date ((dd/mmm/yyyy)	· · · · · · · · · · · · · · · · · · ·			
	CSA)	No Allocation amount \$	· · · · · · · · · · · · · · · · · · ·						
2	Plan member information	Plan member's last name		Fir	st name				
	To be completed	Date of birth (dd/mmm/yyyy)	Sex 🔿 Male	⊖ Female Provi	nce of residence				
	by employee	Language 🔿 English 🔿 Frenc	h Do you have a spor	use? (married, com	mon law or civil union?) O Yes	o No			
3	Plan member address	Address (number, street, apt.)							
		City	Province		Postal code				
4	For Quebec re	sidents (age 65 or over) Are	you participating in the RAM	IQ drug plan?	Yes 🔿 No				
5	Application for coverage	Some plane allow related of certain benefits in the plan member has coverage ander their spease s plan. If you won to add o							
		I am applying for Extended Health 0	Care for	I am applying for	Dental Care for				
		O Myself only		O Myself only					
		O Myself and 1 dependant (child	or spouse)	O Myself and ?	l dependant (child or spouse)				
		O Myself and 2 or more dependation	nts (spouse and children)	O Myself and 2	2 or more dependants (spouse an	d children)			
		 None, because my spouse has 	coverage	None, becau	use my spouse has coverage				
		Are you applying for Dependant Life	e? OYes ONo	Dependant Life	may be mandatory. Refer to the p	olicy details.			
6	Coordination	This section is required if you are applying for coverage on your dependants.							
	of benefits	Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? O Yes O No							
		If yes, please provide the following	details: Name of othe	r insurer					
Ins	sured's last name	I	First name		_ Date of birth (dd/mmm/yyyy) _				
Eff	ective date of covera	ge (dd/mmm/yyyy)	Identification/certificate num	ber	Policy number _				
Ε.			Extended Usetth	Popofita	Dontol Coro				
Ple	ease indicate type of	coverage under other plan:	Extended Health	DEHEIIIS	Dental Care				
	cases where the info default value of Seco	rmation is not complete,							
d (iuary will be applied.	⊖ Family		⊖ Family				
			O None		O None				

7	Dependant information Spouse here is not enough to list your bendants, attach ails on a separate eet.	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.											
IF +1		Last name			First name				Date of birth (dd/mmm/yyyy)				
roc dej		Sex											
		*To a	*To apply for over-age disabled dependant coverage, please complete form GL0514E.										
Las	st name			First name			Date of birth (dd/mmm/yyyy)		l	Sex Male Female		Over-age student	Over-age disabled dependant*
										\bigcirc	\bigcirc	\bigcirc	\bigcirc
										\bigcirc	\bigcirc	\bigcirc	\bigcirc
										\bigcirc	\bigcirc	\bigcirc	\bigcirc
										\bigcirc	\bigcirc	\bigcirc	\bigcirc
	Banking information and email address Complete only when providing new or updated information.	a 7	be deposited Locate your b on your perso	your banking our claim payme directly to your a anking informat anal cheque or b contact your bra	account. ion ank	MEMO III 10 8 III Transit r	" <u>01122</u> ""	5401: 00			<u>1 1</u> ⊪• ount numb	er	
		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 addre	ss (Please prir	nt clearly)								

9 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife. **Lunderstand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **Lcertify** that the information in this form is true and complete to the best of my knowledge. **Lunderstand** 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. **Lacknowledge 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. **Lauthorize** 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"). **Lauthorize** 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. **Lam 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. **Lauthorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **Lauthorize** 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. **Lagree** the polycopy or electronic version of this authorization is valid.

If applicable, <u>Lauthorize</u> 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. <u>Lconfirm</u> 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.

Lunderstand 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). Lalso 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). Lalso 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, <u>Lauthorize</u> Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. <u>Lunderstand</u> 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. <u>Lagree</u> 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. <u>Lagree</u> should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. <u>Lunderstand</u> 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.

Lunderstand 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.

Lacknowledge 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			

III Manulife

Please see reverse for assistance in completing this form.

Send the completed form to: Plan Member Administration Manulife

PO BOX 11006, STN CENTRE-VILLE

MONTREAL QC H3C 4T8

Fax: 1-877-733-4233

Group Benefits Beneficiary Designation

All sections of this page should be completed as it will replace any prior designations.

Plan member name (last, first and middle initial) Province of resi Name of beneficiary (last, first and middle initial) Date of birth (dd/mmm	yyyy) Relationship to plan member Percentage								
2 Primary honoficiany Name of beneficiary (last first and middle initial) Date of birth (dd/mmm									
2 Primary beneficiary Name of beneficiary (last, first and middle initial) Date of birth (dd/mmm/	%								
List all primary beneficiaries for Basic Life and/or Basic Accidental Death. Date of birth (dd/mmm/									
Percentages must total 100% to be valid. Date of birth (dd/mmm/	yyyy) Relationship to plan member Percentage %								
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	For Quebec residents only lation of your spouse as beneficiary is irrevocable unless otherwise specified. se is beneficiary, the designation is: levocable O Irrevocable								
3 Optional coverage (if applicable) Name of beneficiary (last, first and middle initial) Date of birth (dd/mmm/	yyyy) Relationship to plan member Percentage %								
Plan contract number Name of beneficiary (last, first and middle initial) Date of birth (dd/mmm/	yyyy) Relationship to plan member Percentage %								
List all beneficiaries for Optional Life and/or Optional Accidental Death.	yyyy) Relationship to plan member Percentage %								
Irrevocability 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 In Quebec, the design If spour	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								
4 Contingent beneficiary You may wish to designate a contingent beneficiary(ies) to receive any p the primary beneficiary(ies), named above for either coverage, should d beneficiary will automatically be entitled to the benefit that would have b If you name more than one contingent beneficiary, then the proceeds will beneficiaries you choose to name. Should there not be any surviving be proceeds will be paid to your estate. Name of contingent beneficiary (last, first and middle initial)	e before you. In that event, a contingent een payable to the primary beneficiary(ies). I be split, evenly, amongst the contingent neficiaries at the time of your death, the								
Name of contingent beneficiary (last, first and middle initial) Date of birth (dd/r	nmm/yyyy) Relationship to plan member								
5 Trustee appointment									
Complete if any beneficiary named is under the age of majority.									
Declaration and authorization Lhereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and person(s) named above.									
be kept in a Group Life and Health Benefits file. Access to your informat esignation must be signed and dated to be valid. be kept in a Group Life and Health Benefits file. Access to your informat • our employees and service representatives in the performance of th • persons to whom you have granted access; and • persons authorized by law.	• persons authorized by law. You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate								
is as valid as the original. I acknowledge that more detailed information concerning how and why	Lacknowledge that more detailed information concerning how and why Manulife collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.								
Plan member signature	Date signed (dd/mmm/yyyy)								

Manulife assumes no responsibility for the validity or sufficiency of the content provided by you. The items 'you' and 'yours' refer to the plan member, the term "Plan Sponsor" refers to the entity that offers the group benefits plan, such as an employer.

What is the purpose of a beneficiary?

If you intend for some or all of your death benefit to go to specific individuals, it is important to make sure that you plan ahead and select those beneficiaries. Having an up-to-date beneficiary designation will make this possible by listing your primary and contingent beneficiaries and intended allocations.

Beneficiary: the person, people or entity who will receive any death benefit from the basic or optional coverage you have selected through your group benefits plan that becomes payable upon your death. Basic and optional beneficiaries may differ.

Types of beneficiary – Primary vs. Contingent

Primary: the person, people or entity you choose to receive the death benefits. If you choose more than one beneficiary, you will need to indicate what percentage of the benefit you would like each person to receive. When multiple primary beneficiaries are named, the total of the percentages allocated to each primary beneficiary must add up to 100%.

Contingent: the person, people or entity you designate to receive the death benefits if all of the primary beneficiaries die before you. If you select more than one contingent beneficiary, the benefit will be split evenly between the contingent beneficiaries.

What happens to the death benefit when					
The primary beneficiary dies before you and no contingent beneficiary is named.	The death benefit will be paid to your estate.				
The primary beneficiary dies before you, but there is a contingent beneficiary(ies) designated.	The benefit will be paid to the contingent beneficiary(ies).				
You assign two primary beneficiaries, and one beneficiary dies before you, and you have not updated your beneficiary form information.	The entire death benefit that would have been paid to the deceased beneficiary will be paid to the surviving primary beneficiary.				

Irrevocable vs. Revocable

Irrevocable: the beneficiary you choose cannot be changed without the written permission of that individual. For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you will not be able to change the beneficiary designation without a completed release form from them.

In Quebec, naming your spouse (must be a civil union) as a beneficiary automatically means that he/she is an irrevocable beneficiary, unless you specify otherwise or divorce.

Revocable: a revocable beneficiary means that the beneficiary you choose can be changed at any time without the permission of that individual.

For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you can then change that beneficiary designation without asking for that person's permission.

Naming a minor as a beneficiary

If a benefit becomes payable to a minor who is named as a primary or contingent beneficiary, the benefit can only be paid on behalf of the minor to a trustee or guardian for property, otherwise it will be paid into court to be held until the beneficiary has reached the age of majority for your specific province. It is important therefore, if you are choosing a beneficiary who is a minor at the time of the designation to also name a trustee.

If you are a Quebec resident, the parents are considered tutors of their child.

If a minor has been designated as an irrevocable beneficiary, the policy is automatically frozen until the beneficiary has reached the age of majority for your specific province. A parent, guardian or trustee cannot consent to a beneficiary change on behalf of a minor.

Minor: a person named as a beneficiary who is under the age of majority for your specific province.

Trustee: a person appointed by you to hold the minor's proceeds in trust until the minor reaches the age of majority for your specific province.

Tutor: a tutor acts like a trustee.