

Does each applicant have provincial/territorial health care coverage? Yes No

Agent ID: ON1487

NOTE: All applicants **must** have coverage under a provincial/territorial health care insurance plan in order to be eligible for this insurance product. If anyone on the application does not meet this requirement, please contact Manulife at **1-877-551-5566** for more information.

Part A • General Information

Applicant's Information

Last Name _____
 First Name _____ Initial _____
 Home Telephone (_____) _____
 Business Telephone (_____) _____
 Fax _____
 Email _____

Co-Applicant's Information (if applying)

Last Name _____
 First Name _____ Initial _____
 Home Telephone (_____) _____
 Business Telephone (_____) _____
 Fax _____
 Email _____

Applicant's Address:

Address _____ Province _____
 City _____ Postal Code _____

If additional information is required, how may we contact you? Email Home Business Best time to call _____ AM PM

Are you now covered or did you previously have health insurance coverage with Manulife or any other insurance company? Yes No
 If "Yes," please indicate:

Plan Number _____ ID Number _____
 Insurance Company _____
 Date Benefits Ended _____
(DD/MM/YYYY)

Plan Number _____ ID Number _____
 Insurance Company _____
 Date Benefits Ended _____
(DD/MM/YYYY)

Quebec residents: Is this application intended to replace current coverage other than your current or recently ended group health plan? Yes No

If you intend to replace coverage other than your current or recently ended group health plan, do not cancel your existing coverage. Manulife may not be able to issue a policy where replacement of an existing insurance product is intended.

Part B • Beneficiary Designation

Applicant's Beneficiary

I hereby designate the individual(s) named as beneficiary(ies) for payment of the Accidental Death & Dismemberment benefit. In case of death, if no beneficiary is designated, benefits will be payable to the Estate.

Last Name _____
 First Name _____
 Relationship to Applicant _____

Co-Applicant's Beneficiary

I hereby designate the individual(s) named as beneficiary(ies) for payment of the Accidental Death & Dismemberment benefit. In case of death, if no beneficiary is designated, benefits will be payable to the Estate.

Last Name _____
 First Name _____
 Relationship to Co-Applicant _____

Part B • Beneficiary Designation (continued)

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed. By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee: Last Name _____ First Name _____ Relationship to Beneficiary _____	Trustee: Last Name _____ First Name _____ Relationship to Beneficiary _____
---	---

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is revocable.)

<input type="checkbox"/> I hereby declare and stipulate that the beneficiary designation made in this form is revocable.	<input type="checkbox"/> I hereby declare and stipulate that the beneficiary designation made in this form is revocable.
--	--

Part C • Plan Choice

I am/We are applying for: **Basic** **Enhanced** **Enhanced Plus** **Premiere**

Part D • Individuals To Be Covered

First name	Last name	Code	Sex	Birth date DD MM YYYY
Applicant		00		
Co-Applicant		01		
Dependant		02		
Dependant		02		

Part E • Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial 2 months' premium, \$ _____, using my/our:

Option 1: Financial Institution Account **Option 2:** Credit Card Account

Subsequent Payments:

Option 1 Pre-Authorized Debit (PAD) from my/our financial institution account - **Please complete PART F.**

Billing Frequency: Monthly Semi-annual (2% discount) Annual (4% discount)

Important: For verification purposes we require a VOID cheque.

Option 2 Credit Card - **Please complete PART F below.**

Billing Frequency: Monthly Semi-annual Annual

Visa MasterCard American Express Card No. _____ Expiry Date _____

Please note: Billing frequency discounts are not available for Credit Card payment options.

(MM/YYYY)

Option 3 Direct Billing

Billing Frequency: Semi-annual (2% discount) Annual (4% discount)

Part F • Payment Information and Authorization

PAYMENT INFORMATION For Pre-Authorized Debit (PAD) Payment Options

Name of Account Holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Transit Number _____

Type of Account: Personal Chequing Chequing/Savings Savings Current Direct Deposit Account Other

Joint Accounts: Is this a joint account requiring only one signature? Yes No

If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

PAYMENT AUTHORIZATION For Pre-Authorized Debit (PAD) Payment Options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by Payments Canada in Rule H-1. I/We or Manulife may end this agreement at any time by giving **10 days' written notice**. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact Manulife at: 1-877-551-5566 or am_info@manulife.com or write to Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a reimbursement claim, or for more information on your recourse rights, you may contact your financial institution or visit www.payments.ca.

Name of Account Holder _____ Signature of Account Holder _____

Second Signature If Joint Account _____ Dated _____
(DD/MM/YYYY)

Account Holder Address (if different from Applicant) _____

PAYMENT AUTHORIZATION For Credit Card Payment Options

I/We hereby authorize Manulife to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This authorization may be terminated by either Manulife or by me/us through written notice.

Manulife may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A \$25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

Second Signature if Joint Account _____ Dated _____
(DD/MM/YYYY)

Declaration and Authorization • All Applicants Must Complete This Section

I/We acknowledge having read and I/we agree with the Notice on Privacy and Confidentiality. I/We hereby acknowledge that the statements contained herein are true and complete and, together with any other forms signed by me/us in connection with this application, form the basis for any Policy issued hereunder. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive any Accidental Death and Dismemberment proceeds payable.

Signature of Applicant _____ Signed at _____ Dated _____
(City/Province) (DD/MM/YYYY)

Signature of Co-Applicant _____ Signed at _____ Dated _____
(City/Province) (DD/MM/YYYY)

If you have any questions, please call Manulife at 1-877-551-5566.

Mail completed application to Manulife, P.O. Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

FollowMe™ Health Insurance is underwritten by The Manufacturers Life Insurance Company (Manulife).

Manulife, the Block Design and FollowMe are trademarks of The Manufacturers Life Insurance Company and are used by it, and by its affiliates under licence.

© 2017 The Manufacturers Life Insurance Company. All rights reserved. Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

Accessible formats and communication supports are available upon request. Visit manulife.com/accessibility for more information.

170013 04/2017