APPLICATION FORM
FollowMe™ Life Insurance for CARP Members

The Manufacturers Life Insurance Company

11901 001 P0EX0

FM-LIFE-APP-CARPN.E (01/17)

Primary Applicant Information

Last Name ______

First Name ______ Initial ______

Address ______ City ______

Province ______ Postal Code ______

Date of Birth ______ (DD / MM / YYYY) Sex ☐ Male ☐ Female

Telephone (Res.) ______

Telephone (Bus.) ______

Email ______

Please provide information about your current or recently ended group life plan:

Employer Name ______

Insurance Company ______

Date Benefits End(ed) ______ (DD / MM / YYYY)

Life Benefit Amount ______

Group and Identification Numbers ______

Spouse Information (if applying for coverage)

Last Name ______

First Name ______ Initial ______

Address ______ City ______

Province ______ Postal Code ______

Date of Birth ______ (DD / MM / YYYY) Sex ☐ Male ☐ Female

Telephone (Res.) ______

Telephone (Bus.) ______

Email ______

Please provide information about your coverage under the primary applicant's current or recently ended group life plan:

Employer Name ______

Insurance Company ______

Date Benefits End(ed) ______ (DD / MM / YYYY)

Life Benefit Amount ______

Group and Identification Numbers ______

Coverage Amount

If you intend to replace coverage (other than coverage you may have through an employer group benefits plan), do not cancel your existing coverage until you receive your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Primary Applicant: I am applying for $ ______ in coverage.

Spouse: I am applying for $ ______ in coverage.

(Available from $25,000 to $200,000. You are eligible to apply for FollowMe™ Life coverage equal to or less than your group life coverage amount.)

Primary Applicant: ☐ Smoker ☐ Non-Smoker*

Spouse: ☐ Smoker ☐ Non-Smoker*

**Non-smoker rates apply to people who have not used tobacco or marijuana in any form, including smoking cessation products, in the last 12 months.*

Beneficiary Information

☐ I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary on Member Coverage

Last Name ______

First Name ______

Relationship to Member ______

Beneficiary Information

☐ I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary on Spouse Coverage

Last Name ______

First Name ______

Relationship to Spouse ______

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.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Payment Options

PAYMENTS will be made by:

Option #1 ☐ **Pre-Authorized Monthly Debit** (PAD) plan from my Financial Services Account
Important: Please enclose a sample cheque marked "VOID".

Option #2 ☐ **Credit Card:** ☐ Visa ☐ MasterCard ☐ American Express **Billing Frequency:** ☐ Monthly ☐ Annual

Credit Card No. ____ ____ ____ ____ Expiry Date ____ (M M | Y Y)

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 withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date I/we sign this authorization. I/We authorize Manulife to withdraw premiums **on or about the first business day of each month** or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If my/our 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 me/us for an alternate method of payment if my/our payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We and/or Manulife can end this agreement at any time by giving **10 days' written notice**. I/We understand that cancelling this PAD agreement may result in a 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.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact Manulife at 1-800-396-4389, am_info@manulife.com or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario 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.cdnpay.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 – Please read carefully before signing.

I/We hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I/We (the undersigned) declare that the statements contained in this application form are true and complete. I/We understand that the application form, together with any other forms signed by me/us in connection with this application, forms the basis for any policy issued hereunder. I/We understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the Insurer. I/We have read and understand that there are exclusions and limitations on the coverage applied for, including an exclusion for pre-existing conditions. Suicide within two years of the effective date is a risk not covered. I/We understand that insurance will take effect on the date the application form and payment of the first premium are received by Manulife at its office. I/We acknowledge receipt of, and agree with, the Notice on Privacy and Confidentiality and the Notice on Exchange of Information in the brochure. A photocopy or fax copy of this signed declaration shall be as valid as the original.

Signed at ______________ Date ______________ (DD / MM / YYYY) Applicant's Signature ______________________

Signed at ______________ Date ______________ (DD / MM / YYYY) Spouse's Signature ______________________ (if spouse is applying for coverage)

If you have any questions, please call Manulife at **1-800-396-4389**
Mail completed application to **Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.**

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