APPLICATION FORM
FollowMe™ Health for CARP Members

THE MANUFACTURERS LIFE INSURANCE COMPANY

All Applicants must complete **Parts A**, **B**, **C**, **D, E** and **F** of the application form.
All Applicants must complete and sign the **Applicant's Declaration.**

WSE

Agent ID:
ON1487

FM-CARP-APP.NE (09/14)

Part A • General Information

Primary Applicant's Address

Address ______________________ City ______________________

Province ______________ Postal Code ______________ Home Telephone ( ) ______________

Primary Applicant's Information

Last Name ______________________

First Name ______________ Initial ______

Business Telephone ( ) ______________ Fax ( ) ______________

E-mail ______________________

Co-Applicant's Information

Last Name ______________________

First Name ______________ Initial ______

Business Telephone ( ) ______________ Fax ( ) ______________

E-mail ______________________

If additional information is required, how may we contact you? ❑ E-mail ❑ Home telephone ❑ Business telephone Best time to call ______________ ❑ AM ❑ PM

Are you now covered by 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)

Part B • Beneficiary Designation

Beneficiary Designation for payment of Accidental Death & Dismemberment benefit. In case of death, if no beneficiary designation is made, benefits will be payable to the estate.

Primary Applicant's Beneficiary

Last Name ______________ First Name ______________

Relationship to Primary Applicant ______________________

Co-Applicant's Beneficiary

Last Name ______________ First Name ______________

Relationship to Co-Applicant ______________________

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 ______________________

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	GOVERNMENT HEALTH CARD NO.	CODE	SEX	BIRTH DATE DD	MM	YYYY
PRIMARY 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, $ ____________, from my/our:
Option 1 ❑ Financial Institution Account (Pre-Authorized Debit) **Option 2** ❑ Credit Card Account

Subsequent Payments will be made by:

Option 1 ❑ Pre-Authorized Debit (PAD) *(Please read, complete and sign PART F):*
Billing Frequency: ❑ Monthly ❑ Semi-annually (2% discount) ❑ Annually (4% discount)
Important: For verification purposes we require a VOID cheque.

Option 2 ❑ Credit Card *(Please read, complete and sign PART F):*
Billing Frequency: ❑ Monthly ❑ Semi-annually ❑ Annually
❑ Visa ❑ MasterCard ❑ American Express Card No. ______________________________ Expiry Date ______________ (MM/YYYY)
Please note: Billing frequency discounts are not available for Credit Card payment options.

Option 3 ❑ Direct Billing:
Billing Frequency: ❑ Semi-annually (2% discount) ❑ Annually (4% discount)

IF YOU REQUIRE ADDITIONAL SPACE TO COMPLETE ANY PART OF THIS APPLICATION, PLEASE ATTACH A SEPARATE SHEET.

Part F • Payment Information and Authorization

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 ❑ 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 the Canadian Payments Association 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.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-551-5566, by e-mail at 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) ______________________________

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)

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to the Privacy Officer at: Affinity Markets, Manulife, P.O. Box 4213, Stn. A, Toronto, Ontario M5W 5M3.

Applicant's Declaration • All Applicants Must Complete This Section

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 acknowledge having read and I/we agree with the Notice on Privacy and Confidentiality as stated in this document. 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 Primary Applicant ______________________ Signed at ______________________ (City/Province) Date ______________________ (DD/MM/YYYY)

Signature of Co-Applicant ______________________ Signed at ______________________ (City/Province) Date ______________________ (DD/MM/YYYY)

Call 1.877.551.5566 if you require any assistance in completing this application.

Plan underwritten by

The Manufacturers Life Insurance Company

Manulife, PO Box 4213, Stn A, Toronto Ontario M5W 5M3

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