FollowMe™ Life Application Form

10111 001 PCES7

Primary Applicant Information

Last Name _____ First Name _____ Initial ___

Address _____

City _____

Province _____ Postal Code _____

Date of Birth: DD / MM / YYYY ☐ Male ☐ Female

Telephone (Res.) ( ) _____

Telephone (Bus.) ( ) _____

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

Employer Name _____ Insurance Company _____

Life Benefit Amount _____ Date Benefits End(ed) _____

Group and Identification Numbers _____

Choice of Coverage

I apply for FollowMe™ Life coverage:

Amount of 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.)

☐ 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

Beneficiary on Primary Applicant's Coverage

I hereby designate the individual(s) named as beneficiary below to receive any death benefit payable with respect to the coverage applied for.

Beneficiary(ies):

1. Last Name _____ First Name _____

   Relationship to Primary Applicant _____ % of Benefit _____

2. Last Name _____ First Name _____

   Relationship to Primary Applicant _____ % of Benefit _____

If you designate a beneficiary under the age of 18, benefits will be paid into court unless a trustee is appointed; except in Quebec, where benefits will be paid directly to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee:

Last Name _____ First Name _____

Relationship to Primary Applicant _____

Spouse Information (if applying for coverage)

Last Name _____ First Name _____ Initial ___

Address _____

City _____

Province _____ Postal Code _____

Date of Birth: DD / MM / YYYY ☐ Male ☐ Female

Telephone (Res.) ( ) _____

Telephone (Bus.) ( ) _____

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

Employer Name _____ Insurance Company _____

Life Benefit Amount _____ Date Benefits End(ed) _____

Group and Identification Numbers _____

Choice of Coverage

I apply for FollowMe™ Life coverage:

Amount of coverage $ _____

(Available from $25,000 to $200,000; you are eligible to apply for FollowMe Life coverage equal to or less than your coverage amount under your spouse's group life plan.)

☐ 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

Beneficiary on Spouse's Coverage

I hereby designate the individual(s) named as beneficiary below to receive any death benefit payable with respect to the coverage applied for.

Beneficiary(ies):

1. Last Name _____ First Name _____

   Relationship to Spouse _____ % of Benefit _____

2. Last Name _____ First Name _____

   Relationship to Spouse _____ % of Benefit _____

If you designate a beneficiary under the age of 18, benefits will be paid into court unless a trustee is appointed; except in Quebec, where benefits will be paid directly to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee:

Last Name _____ First Name _____

Relationship to Spouse _____

Please complete both sides >

Payment Options

PAYMENTS will be made by: Option #1 ❑ Pre-Authorized Monthly Collection (PAC) plan from my Financial Services Account

Important: Please enclose a sample cheque marked "VOID".

Option #2 ❑ Credit Card Account

Credit Card Billing Frequency: ❑ Monthly ❑ Annually

Payment Information and Authorization

For Pre-Authorized Collection (PAC) Options

Name of Account holder (if other than Applicant) _____

Financial Institution _____

Type of Account: ❑ Chequing ❑ Non-Chequing

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 the authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payment 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.

For Credit Card Payment Options

Credit Card: ❑ Visa ❑ MasterCard ❑ Amex

Account Number: _____ Expiry Date: MM / YY

Name of Account holder (if other than Applicant) _____

Payment Authorization

For Pre-Authorized Collection and Credit Card billing options — I/We hereby authorize Manulife Financial 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 Financial or by me/us through written notice. Manulife Financial 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.

_____ _____

Signature of Cardholder or Account holder Second signature if joint account

Declaration – Please read carefully before signing.

❑ Check here if you do not wish to receive further information and material on Manulife Financial products.

I/We, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/We declare that the statements contained in this application 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 that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date is a risk not covered. I/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that insurance will take effect on the date the application and payment of the first premium are received by Manulife Financial at its office.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death.

I/We acknowledge receipt of, and agree with, the Notice on Privacy and Confidentiality as stated within the brochure.

By signing this application, each applicant declares that he/she is not currently ill or injured or, where the Primary Applicant's group life plan has already ended, was not ill or injured at the time the Plan ended.

Important: This product is not intended as replacement insurance for any life insurance you may have. Please do not cancel your existing coverage.

Signed at: _____ Date: DD / MM / YYYY Applicant's Signature _____

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

Manulife Financial