Manulife Financial

For your future™

Group Benefits – Enrolment or Re-enrolment Application

Please print clearly and complete all applicable pages of form. If required, retain a photocopy for your files.

1 Plan sponsor statement

To be completed and signed by plan sponsor.

Enter member's certificate number, if known. Otherwise leave blank for Manulife Financial to complete.

Plan contract number	Account/Division number	Billing division (if applicable)	Plan member certificate number
632057	001		

Plan sponsor name	Plan sponsor telephone number
Foursquare Gospel Church of Canada	(604) 941-8414

Provide **permanent** full time hire date (dd/mmm/yyyy)	If a re-hire, provide the date previous employment ended (dd/mmm/yyyy)	Re-hire date (dd/mmm/yyyy)

Do you want the waiting period added to the permanent full time hire date? ◯ Yes ◯ No

Plan member's occupation	Class	Regular hrs./week	Annual earnings
	A		$

I certify that the **plan member** listed below is **actively at work** at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature	Date signed (dd/mmm/yyyy)

In order to determine if evidence of insurability is required, please refer to your contract.

Is evidence of insurability required? ◯ Yes ◉ No

If evidence of insurability is required, plan members must complete GL0004E, *Evidence of Insurability*, and send it to Manulife Financial for processing.

2 Plan member information

We require this information to enrol you in the plan.

Plan member name (last, first, middle initial) (please print)	Date of birth (dd/mmm/yyyy)

Sex	Province of residence	Language of preference
◯ Male ◯ Female		◯ English ◯ French

3 Plan member address

Address (number, street, apt.)		
City	**Province**	**Postal code**

4 For Quebec residents (age 65 or over)

◯ I am participating in the RAMQ drug plan provided by the Quebec government

◯ I am NOT participating in the RAMQ drug plan provided by the Quebec government

5 Applying for coverage

Note: Some plans allow you to refuse certain benefits if you have coverage under a spouse's plan. If you wish to add coverage at a later date you may reapply for these benefits at which time satisfactory medical evidence may be required.

Applying for Health and Dental Benefits

Health	Dental		Health	Dental	
◯	◯	Myself ONLY	◯	◯	Myself and 2 or more dependants/spouse
◯	◯	Myself AND 1 dependant/spouse	◯	◯	None, because my spouse has coverage

Dependant Life

◯ Yes ◯ No

6 Spousal information

Spouse's name (last, first, middle initial)	**Date of birth** (dd/mmm/yyyy)	**Sex** (M or F)	**If common-law spouse, provide the date the co-habitation commenced** (dd/mmm/yyyy)
		◯ M ◯ F	

7 Spousal coordination of benefits

This section is required if you have a spouse and are applying for coverage on your dependants. In cases where the information is not complete a default value will be applied.

Spousal Health Coverage	Does your spouse have health coverage under his/her own insurance plan?	◯ Yes ◯ No	Effective date (dd/mmm/yyyy)
Spousal Dental Coverage	Does your spouse have dental coverage under his/her own insurance plan?	◯ Yes ◯ No	Effective date (dd/mmm/yyyy)

Does your spouse's health/dental plan cover:

Health	Dental		Health	Dental	
◯	◯	Your spouse only	◯	◯	Your spouse and children only
◯	◯	Your spouse and yourself only	◯	◯	Your spouse, you and your children

8 Eligible dependant child information

In cases where this information is not complete a default value will be applied.

If there is not enough room to list your dependants, attach details on a separate sheet.

If a dependant is disabled and over-age, please complete GL0514E, *Application for Over-Age Disabled Dependant Coverage*.

Dependant name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Student	Year enrolled	Is this dependant covered under your plan?	Is this dependant covered under your SPOUSE'S plan?
		◯ M ◯ F	◯ Yes ◯ No		◯ Yes ◯ No	◯ Yes ◯ No
		◯ M ◯ F	◯ Yes ◯ No		◯ Yes ◯ No	◯ Yes ◯ No
		◯ M ◯ F	◯ Yes ◯ No		◯ Yes ◯ No	◯ Yes ◯ No
		◯ M ◯ F	◯ Yes ◯ No		◯ Yes ◯ No	◯ Yes ◯ No
		◯ M ◯ F	◯ Yes ◯ No		◯ Yes ◯ No	◯ Yes ◯ No

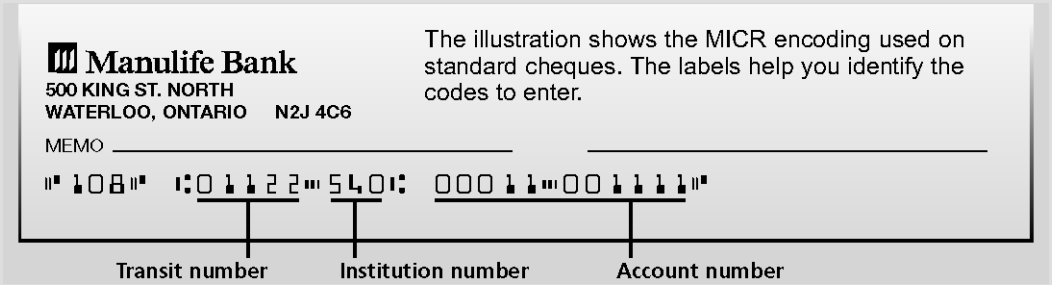
Are any of the above dependent children covered under any other insurance plans (i.e. former spouse's plan, provincial plan)? If so, please complete the following section.

Dependent child name(s)	Dependent child name(s)
Date of birth of member under other plan (dd/mmm/yyyy)	Date of birth of member under other plan (dd/mmm/yyyy)
Relationship to dependant	Relationship to dependant
Is there health coverage? ◯ Yes ◯ No	Is there health coverage? ◯ Yes ◯ No
If *yes*, effective date (dd/mmm/yyyy)	If *yes*, effective date (dd/mmm/yyyy)
Is there dental coverage? ◯ Yes ◯ No	Is there dental coverage? ◯ Yes ◯ No
If *yes*, effective date (dd/mmm/yyyy)	If *yes*, effective date (dd/mmm/yyyy)
Name of other insurance company	Name of other insurance company
Policy number / Certificate number	Policy number / Certificate number

9a Direct deposit

Complete the following section if you would like to sign up for direct deposit of your claim payments.

Name of financial institution			
Address (number, street)	City	Province	Postal code
Transit number (5 digits)	Institution number	Bank account number	



9b Electronic claim statement

By completing the email section, you will be sent an invitation to register for an online member account.

Complete the following section only if your plan offers online services and you wish to enrol for the service.

If the email and banking fields are completed you will receive an electronic claim statement, otherwise you will receive your claim statement by mail.

Work email	Personal email

10 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("Manulife"). **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** 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. **I acknowledge 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. **I authorize** 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"). **I authorize** 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. **I am 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. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** 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. **I agree** a photocopy or electronic version of this authorization is valid.

If applicable, **I authorize** 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. **I confirm** 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. **I understand 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). **I also 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). **I also 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, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** 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. **I agree** 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. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

I understand 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.

I acknowledge 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.

Plan member signature

Please sign and date here.

Plan member signature	Date signed (dd/mmm/yyyy)

11 Mailing instructions

Please send the completed form to:

Plan Member Administration
Manulife Financial
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8

NOTE: To appoint a beneficiary please complete the beneficiary designation on the next page.

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Please send the completed form to: **Plan Member Administration**
Manulife Financial
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8

Group Benefits – Beneficiary Designation

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

1 Plan member information

Plan sponsor name	Plan contract number	Plan member certificate number
Foursquare Gospel Church of Canada	632057	
Plan member name (last, first and middle initial)	**Province of residence**	**Date of birth (dd/mmm/yyyy)**

2 Primary Beneficiary

List all primary beneficiaries for Basic Life/or Basic Accidental Death.

Percentages must total 100% to be valid.

Irrevocability

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
			%
			%
			%

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 your designation.**

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

3 Optional coverage (if applicable)

Plan contract number

List all beneficiaries for Optional Life and/or Optional Accidental Death.

Irrevocability

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
			%
			%
			%

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 your designation.**

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

4 Contingent beneficiary

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member

5 Trustee appointment

Complete if any beneficiary named is under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

6 Declaration and authorization

Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid.

PRINT

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

I acknowledge that more detailed information concerning how and why Manulife Financial 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)