CANADIAN FOURSQUARE CHURCH

WWW.FOURSQUARE.CA

Foursquare Benefit Plan Manual

TABLE OF CONTENTS

CANADIAN FOURSQUARE CHURCH

FOURSQUARE BENEFIT PLAN

Administration Manual

INTRODUCTION

The **FOURSQUARE BENEFIT PLAN** presently provides two benefit packages:

PENSION PLAN
GROUP INSURANCE PLAN

These plans are governed by agreements made between the Foursquare Gospel Church of Canada and selected insurance companies. The manual is separated into two sections: Pension Plan and Group Insurance Plan.

Our participation in the Pension Plan was approved in our 1983 National Convention and commenced operation on February 1, 1984. The Group Insurance Plan was approved at our 1984 National Convention and commenced March 1, 1985.

Participation in the Foursquare Benefit Plan is compulsory for all employees that meet the minimum requirements set out by the plan. See Foursquare Administration Manual for policy statements.

Abbreviations used are FBP meaning Foursquare Benefit Plan; PP meaning Pension Plan; GIP meaning Group Insurance Plan.

This Manual is for easy reference only. Final authority for the governing policies of these plans is based on the Master Policies.

NEW ENROLLMENTS

PENSION PLAN

- Submit ENROLLMENT FORM to the FBP Administrator for new plan member. [Note: Please do not sign in the space provided for Plan Administrator on the form]. See APPENDIX B for forms.
- Begin remitting contributions immediately to the FBP Administrator. Please Note: submissions to pension plan are done on an as-received basis. Only payments received at the national office by the employer will be contributed to the pension plan.

GROUP INSURANCE PLAN

- Submit APPLICATION FORM to the FBP Administrator for new plan member. See APPENDIX C for forms.
- Upon receipt of the application, the FBP Administrator will provide the employer with a Premium Estimate for the applicant.
- Begin making deductions from payroll based on this estimate starting in the month of activation.
- Do not remit any payments to the national office until you receive the first billing invoice. This will ensure that the proper premiums are paid.
- Once the member application has been processed, a package will be sent directly to the Member with their cards.
- Forward a copy of the Benefit Plan Coverage booklet to the new member
- An invoice will be sent for the full monthly premiums billed by Manulife Financial. Please use amounts on invoice to calculate portion to deduct from employee.

PAYMENTS

When remitting monthly payments for GIP and PP, please use the MONTHLY PAYMENT DISTRIBUTION BREAKDOWN form provided in APPENDIX A.
Payments made by cheque should be made payable to **FOURSQUARE BENEFIT PLAN.**
Contact the National Office if you would like to set up ONLINE BILL PAYMENT.

APPENDIX A

MONTHLY PAYMENT DISTRIBUTION FORM BY CHEQUE

MONTHLY PAYMENT DISTRIBUTION FORM BY ONLINE BILL PAYMENT

FOURSQUARE BENEFIT PLAN
Monthly Payment Distribution Breakdown

	Group Insurance Plant For the Month of _____			Pension Plan For the Month of _____			
NAME OF EMPLOYEE	EMPLOYER	EMPLOYEE	TOTAL	EMPLOYER	EMPLOYEE Mandatory	EMPLOYEE Voluntary	TOTAL
	TOTAL			TOTAL			

New Full-Time Employee? _____
(Please give them a new Employee Package including a GIP application form)

Change in Payroll (Salary Increase/Decrease, Termination, Retirement, etc.) **Salary Amount** _____

Name_____ **Date of Change** _____

Address change? Participant Name & Address_____

_____**Postal Code** _____

Change in Marital or Dependent Status: _____

Termination or Retirement _____

Signed_____

Please pay the G.I.P. premiums upon receipt of the invoice.
Pension Plan contributions are done on an as-received basis. Only those payments that are received will be submitted on behalf of the plan member

MONTHLY ONLINE BILL PAYMENT

Foursquare Gospel Church of Canada

ONLINE REMITTANCE FORM

CHURCH NAME: _____

BILL PAYMENT ACCOUNT#: _____

DATE OF ONLINE BILL PAYMENT: _____

INSTRUCTIONS:

1. Enter Church Name, Bill Payment Account# & Date
2. Enter Tithes, Missions & Other Payment amounts in Section A
3. Total the amount in Section A
4. Enter Foursquare Benefit Plan amounts in Section B
5. Total the amount in Section B
6. Enter the Grand Total (A+B) in Section C
7. Send this form to donations@foursquare.ca

SECTION A: Foursquare Gospel Church of Canada General Account

1. Extension Tithe $_____
2. A/R— Invoice #_____ $_____

Explain: _____

3. Loan Payment $_____

Explain: _____

4. License Fee $_____

For who: _____

5. Convention Fee $_____

For who: _____

6. Chilliwack Lake Camp $_____

Explain: _____

7. Foursquare General Missions $_____
8. Foursquare Kids

   India Kids $_____

   Other Kids Program $_____

Explain: _____

9. Other Designated Missions $_____

Explain: _____ $_____

_____ $_____

_____ $_____

10. Other $_____

Explain: _____

_____

TOTAL $ 0.00

SECTION B: Foursquare Benefit Plan Account

NAME OF EMPLOYEE	GROUP INSURANCE PREMIUM			PENSION PLAN CONTRIBUTIONS			
	For the Month Of _____			For the Month Of _____			
	Employer	Employee	TOTAL	Employer	Employee Mandatory	Employee Voluntary	TOTAL
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
			$ 0.00				$ 0.00
SUBTOTAL:	$ 0.00	$ 0.00		$ 0.00	$ 0.00	$ 0.00	
			GIP TOTAL $ 0.00				**PP TOTAL** $ 0.00

Group Insurance + Pension Plan TOTAL: $ 0.00

If there are any changes to be made to the FBP please submit a "Notification of Changes" form.

SECTION C: Grand Total

Section A $ 0.00 **+ Section B $** 0.00 **= Grand Total C $** 125.00

SUBMIT FORM

FOURSQUARE GOSPEL CHURCH OF CANADA
B307 - 2099 Lougheed Hwy, Port Coquitlam
British Columbia, Canada, V3B 1A8
P: 604 941 8414 F: 604 941 8415
E: info@foursquare.ca W: foursquare.ca

CONTACT INFORMATION

MANULIFE CUSTOMER SERVICE REPRESENTATIVE
(888) 727-7766
www.manulife.ca/GRO

INVESTMENT ADVISOR:
Greg Wyatt
Schmunk, Gatt, Smith & Associates
Suite 204 – 20334 56th Avenue
Langley, BC V3A 3Y7
(604) 533-9813

TABLE OF CONTENTS

REGISTRATION NUMBER

This plan is registered with Canada Revenue Agency (CRA) and both the contributions deducted from employee's salaries and paid by the church must be reported on the required annual T4 slips (Box 20 and 52). The Registration Number should also be reported on the T4 (Box 50).

Please see Administrator's Guide for further instructions on proper payroll procedures.

TYPE OF PLAN

This is a Defined Contribution plan where our liabilities are known (as a selected percentage of payroll). The total employer and employee contributions are accumulated and continually invested under the direction of Manufacturers Life Insurance Company.

PARTICIPATION REQUIREMENTS

This plan is applicable to all activities falling under the general administration of the Foursquare Gospel Church of Canada and our agreement with Manulife with makes participation by all qualified employees mandatory. The amount of contribution by the employer and the employee is flexible.

Throughout this Manual "employer" refers to our individual churches and other activities of the Foursquare Gospel Church of Canada.

This is a joint participation plan, with a percentage of the employee's total compensation from the church being contributed by both the employee and the employer.

The employee can vary the level of their participation from a minimum of 3% of total compensation to a maximum of 7%. Participation levels will be in even 1% increments. Total compensation is defined as all monthly funds expended by the employer in support of the employee. Ie. Salary plus benefits, but does not include non-routine or reimbursable expenses, nor EI or CPP payments.

The employer contributions can vary between a minimum of 3% to a maximum of 10% of total compensation. Each local church council should decide and approve the level of employer contribution.

The employee and employer may change their level of contribution, upward or downward, once per year on the anniversary date of the employee joining the plan.

EMPLOYEE ENROLLMENT REQUIREMENTS

A regular employee must wait one year from the date of employment to become eligible to apply for enrollment in the Pension Plan. A regular employee is defined as one who has been employed and maintains employment for a minimum of 20 hours per week and who receives $2,000 or more per month (salary plus benefits). Part-time employees who meet the requirements under provincial pension legislation must be offered the plan and may choose to participate. If the council chooses to waive the wait period for a new employee they must send a signed letter to the National Office.
If the employee chooses not to participate in the pension plan, they must sign a WAIVER OF PARTICIPATION FORM (found in APPENDIX B)

The employer should ensure that an **ENROLLMENT FORM** is completed as part of the hiring procedure. The employee should provide the employer with a copy of proof of date of birth as this is necessary to ascertain date of vesting and normal retirement date.

The **ENROLLMENT FORM** is sent to the FBP Administrator and a copy should be retained by the employer as it provides the employer authorization to begin payroll deductions on the eligible date. The required form is in Appendix A and should be photocopied as needed.

CHANGE IN INFORMATION

If an employee needs to report a change of information (change of name, marital status, beneficiary) a CHANGE FORM should be completed and forwarded to the FBP Administrator. A copy of this form is included in Appendix A and should be photocopied as needed.

MONTHLY PAYMENTS

Contributions to the Pension Plan are done on an as-received basis. Only those payments that are received by the FBP Administrator will be submitted on behalf of the plan member. In order to ensure that contributions are made on a timely basis it is important that the employer make payments as soon as possible after deduction from employee payroll.

The monthly contributions are forwarded to the FBP Administrator by cheque, made payable to the FOURSQUARE BENEFIT PLAN or Electronic Bill Payment. Many churches have employees participating in both the Pension Plan and Group Insurance Plan. All payments can be included in one monthly cheque.

A copy of the MONTHLY PAYMENT DISTRIBUTION FORM is included in APPENDIX A and should be photocopied as needed.

ADDITIONAL VOLUNTARY CONTRIBUTIONS

A member may make voluntary contributions, in addition to the regular contributions. Amounts may also be transferred into the Plan that were received or receivable by the member as an eligible retiring allowance or a cash withdrawal benefit under any other plan or registered retirement savings plan (subject to the limits allowed under the Income Tax Act.)

Note: All contributions must be made within the taxable year and cannot accumulate. Total contributions cannot exceed the maximum percentage level per taxable year.

RETIREMENT

The retirement age is normally considered to be 65 years. Early retirement benefits may be paid anytime after age 55. Retirement benefits may be delayed beyond age 65, but in no case beyond 69.

Notice of termination is to be provided to the FBP Administrator upon retirement or termination of employment. Member is to give sufficient notice of retirement to the FBP Administrator in order to commence process 90 days in advance of actual retirement date.

AGE 71 PROCEDURES

The Income Tax Act in Canada requires that every individual close their registered savings plans by December 31 of the year in which they turn 71, regardless of their employment situation. Registered savings plans include Registered Retirement Savings Plans (RRSPs), Registered Pension Plans (RPPs), and Deferred Profit Sharing Plans (DPSPs).

To comply with the Income Tax Act, Manulife Financial has put into place the following procedures and deadlines to ensure all Age 71 members' Registered Plans are closed by December 31 of the year they turn 71.

Actions Members must take

- All paperwork must be received by December 16
- On December 17, Manulife Financial will begin processing all funds still in registered plans as follows:

Members with a balance of $5,000 or more

If Manulife does not receive Member instructions by December 16, their assets will be transferred into Manulife's Group Retirement Income Plan. The minimum retirement income payment will be invested in a non-registered savings plan until instructions are received. Once assets are in the Group Retirement Income Plan, they will be governed by applicable retirement income legislation and cannot be transferred back into a registered plan.

Members with a balance of less than $5,000

If Manulife does not receive Member instructions by December 16, their assets will be cashed out and sent to them, minus any applicable taxes. Once the assets are cashed out, the plan will be terminated and the funds cannot be returned to the registered plan. Members will receive a cheque before the end of the year.

TERMINATION OR DISCONTINUANCE OF SALARY

When an individual's employment is terminated, that individual may elect to receive a return of contributions **that are not locked in**, or may choose to leave these funds in the plan until age of retirement. Locked-in regulations vary according to province of employment, so that the amount that is not locked-in will depend on which province the employee last worked.

The locked-in portion of the plan, however, must remain in the plan until normal or early retirement, or may be transferred to a locked-in RRSP. The Member is responsible to notify the FBP Administrator so that a termination can be requested.

In the case of a discontinuance of salary, for leave without pay or moving to a new appointment, notice should be provided to the FBP Administrator. Contributions will be suspended for the duration of the discontinuance. Once salary resumes or new appointment has been established, contributions will be reinstated.

DEATH BENEFITS

In the event of the death of a member prior to retirement, the beneficiary is entitled to a refund of the total of the employee's and the employer's contributions with growth to the date of death.

Within 60 days after the employer learns of the death of a member who has not yet retired, the employer must provide the deceased employee's named beneficiary or legal representative with a statement of any death benefits available.

Immediately upon learning of a member's death the FBP Administrator should be notified so that a NOTICE OF DEATH form can be submitted. A copy of the death certificate will be required to complete the request.

YEARLY REPORTS

Each year members will receive a Pension Statement, which will provide details of that member's pension status. It is the members' responsibility to see that the FBP Administrator has their current address, to allow forwarding of this Pension Statement.

INVESTMENT ADVISOR

Greg Wyatt is the representative of the Pension Plan and is available for consultation on investment options. Any questions with regards to investment choices may be directed to Greg. See section for CONTACT INFORMATION for details.

There is FUND SELECTION GUIDE from MANULIFE found in the APPENDIX as well.

APPENDIX B

MANULIFE ENROLLMENT GUIDE

ENROLLMENT FORM

MANULIFE FUND SELECTION GUIDE

CHANGE FORM

WAIVER OF PARTICIPATION FORM

WITHDRAWAL OR TRANSFER FUNDS

PENSION TERMINATION

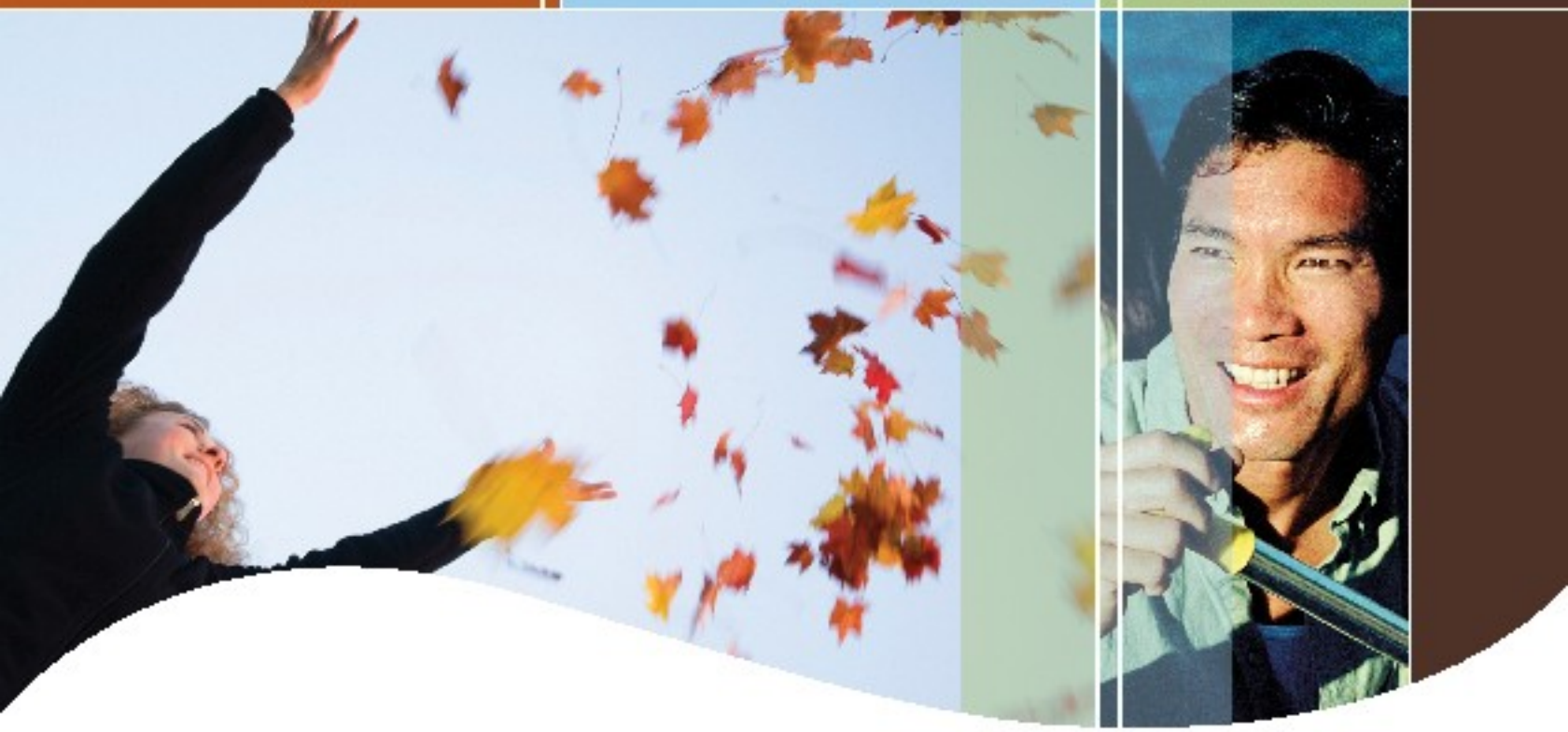
NOTICE OF DEATH

*NOTE: Please send all forms to the National Office for processing. The N.O. will forward the completed forms to Manulife directly.

Manulife Financial
For your future™

WELCOME

Your Enrolment Guide



The Foursquare Gospel Church of Canada Registered Pension Plan

About this Enrolment Guide

This Guide provides information you will need to enroll in your company's Registered Pension Plan.

This process will take a bit of your time, but it will be time well invested. A colour-coded, step-by-step process will help you navigate through this Guide. Each step includes a 'To Do' box showing what you must complete to enroll. The boxes separate what you must do from what you should keep in mind.

Here's what you need to do...

Step one:	**Learn about your program**
Step two:	**Enroll in your plan**
Step three:	**Decide how to invest**
Step four:	**Check to see you've completed each step**

Let's Get Started...

Step one

Learn about your program

To Do!

- ☐ Learn about the advantages of your program.
- ☐ Review the details of your program.

Advantages of the Foursquare Gospel Church of Canada Registered Pension Plan

To help ensure you are prepared for life after work, your Plan Sponsor (employer) has taken the first step toward helping you save for your retirement by offering you a **Registered Pension Plan.** Now, it's up to you to take the next step and join your program.

Your Registered Pension Plan provides many benefits that may not be available to you through an individual savings or investment account, such as:

- **A convenient way to save** – Making regular contributions directly from your pay – before money ever reaches your bank account – makes it easier to commit to saving consistently. Even if the amount you contribute each time is small – and is an amount you're not likely to miss – it can grow very nicely over the long term.
- **Immediate tax reduction** – Regular payroll contributions to Registered Retirement Savings Plans and/or Registered Pension Plans are taken from your gross pay before payroll taxes are calculated. This immediately reduces the amount of your income that's taxed. You'll only pay income tax on the remaining portion of your salary, so you'll enjoy tax savings on each and every pay cheque throughout the year.
- **Tax-deferred growth** – Growth you realize in Registered Retirement Savings Plans, Deferred Profit Sharing Plans or Registered Pension Plans occurs in a tax-sheltered environment until you withdraw funds from the plan.
- **Lower investment management fees** – Take advantage of the competitive investment management fees (IMFs) offered by your group plan. Lower IMFs leave more of your savings in your account and growing for you.
- **Leading fund managers** – Through your group plan, you have access to some of the world's leading fund managers and their funds. Many of these funds aren't available to individual investors.

- **Secure website and telephone account access** – Manage your account and investments using the service option you prefer. Access your account via the secure member website and/or the Customer Service Centre.

- **Easy-to-read statements** – Manulife's member statements provide updates on your savings and include tips and reminders to help you build an effective retirement savings plan.

- **Consolidate your savings** – You can transfer accounts you hold at other institutions to your group program, allowing you to enjoy the above benefits for all of your retirement savings.

Keep reading to learn about the details of your company's program and find out how to join.

Details of your program

The Foursquare Gospel Church of Canada Group Retirement Program includes these plan(s):

- Registered Pension Plan (RPP) – You are **required to join** this plan

The details of your program – shown below – are subject to change by your Plan Sponsor (employer).

	Registered Pension Plan
Policy number	10000971
Who is eligible to join this plan?	All employees.
Do I have to join?	Yes.
When can I join?	After one (1) year of service, with a minimum of 20 hours per week and/or $2000 per month.
How much do I contribute?	You are required to contribute 3-7% of your base salary. Please contact Plan Administrator for further detail. You can make voluntary contributions up to the Canada Revenue Agency (CRA) maximum limit. No plan sponsor matching of your voluntary contributions.
How much does my Plan Sponsor (employer) contribute?	Your plan sponsor will contribute between 3 - 10% of your earnings. Please see plan administrator for further detail.
Who decides how my contributions will be invested?	You do.
Can I transfer money into the plan?	Yes, you may transfer amounts from another registered plan.

	Registered Pension Plan
Can I take money out of the plan while I am employed?	You can withdraw voluntary contributions you make.
Can I make additional one-time contributions?	Yes.
What happens if I leave the company?	The full value of your account belongs to you.
What happens if I retire from the company?	The full value of your account belongs to you.
What happens if I die?	Your beneficiary or beneficiaries will be entitled to the portion of your account that you have specified.

Enroll in your plan

To Do!

☐ Follow the instructions to enroll in the plan.

Detach the **Application form(s)** for the plan(s) below. All forms you need to complete are located at the back of this Guide.

You must join this plan:

Application form for the Registered Pension Plan	Page 13

Complete the following sections on each Application form:

- Tell us about your plan
- Your personal information
- Name your beneficiary (or beneficiaries)

Once you have completed these sections on each **Application form**, go to the next step in your Enrolment Guide.

Step three

Decide how to invest

To Do!

- ☐ Open the Fund Selection Guide you received in this enrolment package.
- ☐ Follow the instructions to determine your investor style and select your investments.

Note - If you consult a Financial Planner for advice regarding funds for this Registered Pension Plan, provide him or her with this Guide. If you do not generally seek the advice of a financial planner before making investment decisions, please continue reading.

Remember: After you're finished with the Fund Selection Guide, you'll need to return to Step four on page 9 in this Guide.

If you do not provide instructions on where to invest contributions to your plan, contributions will be deposited to the plan default investment - ML JF Balanced (5241). You are strongly encouraged to take an active role in how your retirement savings are invested and ensure you are invested in fund(s) that suit you. Your plan's default investment is intended as a temporary destination for your contributions and may not be appropriate for your long-term retirement planning.

Step four

Check to see you've completed each step

To Do!

- ☐ Refer to the checklist below.
- ☐ Return the completed form in the envelope included in your enrolment package. See the list below for details of which form should be returned in which envelope.

Make sure you've fully completed each Application form.

Have you:

- ☐ Completed the *Your personal information* section?
- ☐ Named your beneficiary (or beneficiaries)?
- ☐ Provided instructions on how to invest contributions to your plan?
- ☐ Signed and dated each form?

Your enrolment package includes the following form(s):

- An **Application form** for the Registered Pension Plan (policy 10000971) - return to Foursquare Gospel Church of Canada in the enclosed envelope.

You've successfully enrolled

What's next?

You'll receive a letter from Manulife welcoming you to your group program. This letter will provide your Customer number and explain how you can get your Personal Identification Number (PIN). With your Customer number and PIN, you can access the online tools Manulife offers to help you track and manage your savings.

How can I track the progress of my account?

- **Member statements** – You'll receive regular easy-to-understand member statements updating you about your account activity and growth.
- **Internet** – You can access your account online 24 hours a day, 7 days a week at **www.manulife.ca/GRO.**
- **Phone** – You can contact Customer Service at **1-888-727-7766** to speak with a Manulife Customer Service Representative, Monday to Friday from 8 a.m. to 8 p.m. ET.

What are my responsibilities as a plan member?

To Do!

☐ Review and understand your responsibilities.

Any tax-deferred group savings plan that lets you choose between two or more investment options is known as a Capital Accumulation Plan (CAP).

As a CAP plan member, you have these responsibilities:

- Deciding how much to contribute.
- Making use of the tools and information available to you through your program.
- Selecting your investments.
- Reviewing your investments regularly to ensure they continue to meet your retirement savings and investment goals.

You should also consider obtaining investment advice from an appropriately qualified independent advisor.

Manulife's Customer Service Representatives and Financial Education Specialists are available to help you understand the many planning tools and services you can use.

Call **1-888-727-7766** to speak with a representative, Monday to Friday from 8 a.m. to 8 p.m. ET.

Forms

Here is a list of forms found in your Enrolment Guide:

- An **Application form** for the Registered Pension Plan

Manulife Financial
For your future

Please print clearly in the blank boxes.

Application Form

Sign up for your **Registered Pension Plan (RPP)**

Send your completed form to:

Foursquare Gospel Church of Canada

Rhonda Berkhiem
B307 - 2099 Lougheed Highway, Port Coquitlam, BC, V3B 1A8

If you aren't sure how to complete any of these boxes, the Plan Sponsor/Employer can help you.

Tell us about your plan

Plan Sponsor/Employer **Foursquare Gospel Church of Canada**		Manulife policy number **10000971**
Member Number	Date you started with your employer (mmm/dd/yyyy)	Date you are joining the plan (mmm/dd/yyyy)
Province of Employment		

Your personal information

Gender	First Name	Middle Initial	Last Name
Mailing address (number, street and apartment number)			
City	Province	Country	Postal Code
Date of birth (mmm/dd/yyyy)	Social Insurance Number (SIN)	Marital Status	
Spouse's name		Spouse's date of birth (mmm/dd/yyyy)	
Your preferred language	Telephone number	Ext.	Email address

*A **revocable** beneficiary can be changed at anytime.*

*An **irrevocable** beneficiary can only be changed with written consent from that beneficiary. You will also need your beneficiary's consent to withdraw or transfer money from your account.*

If you want to name more than three beneficiaries, attach a separate page with the names and the percentage of proceeds for each beneficiary.

If you have locked-in money in your RSP and you are married on the date of your death, the law may require any death benefit be paid to your spouse, regardless of other beneficiaries you've named.

If you die while your beneficiary is still a minor, the trustee you name on this form will act on the child's behalf.

Name your beneficiary (or beneficiaries)

If you do not name a beneficiary, proceeds will be paid to your estate.
☐ Check here if you have attached a separate page listing your beneficiaries. Please sign and date.

Name	Relationship	Percentage of proceeds

The above beneficiary designations are considered revocable (if you live outside of Quebec).

If you live in Quebec:
☐ Check here to make your beneficiaries revocable. Otherwise, they will be considered irrevocable.

Trustee for a minor beneficiary named above (not applicable in Quebec)
Any payment to a beneficiary who is a minor will be paid in trust to the trustee named below.

In Quebec, the proceeds will be paid in trust to the minor child's tutor.

Trustee name	Relationship

If you do not complete this section, or the total does not add up to 100%, your contributions will be invested in the plan default fund - ML JF Balanced.

You can go online at anytime to change the funds you have chosen.

The minimum amount you can invest in a fund is 5%.

Percentages must be whole numbers.

Note: the investment performance of a market-based fund is not guaranteed.

**Before you choose a fund that provides a guaranteed income, we encourage you to take a few minutes to learn whether this type of fund is suitable for you. Refer to "The Bold Print" about Manulife's Group IncomePlus for details.*

Your investment instructions

Follow the instructions on page 3 of your Fund Selection Guide to see what type of investor you are. Then fill in **one** of the sections below according to your type.

Complete if *Asset Allocation Fund* is your investment strategy

1. Follow the instructions starting on page 4 of your Fund Selection Guide to determine your investor style and choose your Asset Allocation Fund.
2. Write in the 4-digit fund code for your Asset Allocation Fund below and the percentage you want to invest in this fund.
3. If you decide to invest a portion of your contributions in Group IncomePlus, you need to indicate the percentage you will invest in that fund below*.

Fund Code	Fund name **Manulife Asset Allocation Fund**	Percentage of your contribution
Fund Code	Fund name	Percentage of your contribution

Complete if *Build your own portfolio* is your investment strategy

1. Follow the instructions starting on page 4 of your Fund Selection Guide to determine your investor style and choose your funds.
2. Specify the percentage of contributions you want to invest in each fund. Your percentages must add to 100%.

Fund Code	%	Fund Code	%	Fund Code	%	Fund Code	%
1001		1003		1005		6203*	
3132		4141		4191		5011	
5181		5241		5291		5452	
7121		7131		7132		7141	
7241		7381		8131		8631	
8192		8321		8452		8181	
					Total selected must add up to 100%		**100%**

Please sign here

You confirm that you have read, understood and agreed to the information in this form, including the *Enrolment and Registration Authorization* section below, and the *Personal Information Statement*. You also confirm that information in this form is correct to the best of your knowledge.

Enrolment and Registration Authorization

You request that Manulife enroll you as a Member in this plan. If applicable, you authorize the Plan Sponsor/Employer to deduct your contributions to the plan from your earnings.

If you have selected Group IncomePlus, you acknowledge that you have read and understood The Bold Print and by signing below, you agree to the terms, conditions and fees applicable to that option.

Your signature	Date signed (mmm/dd/yyyy)
Plan administrator's signature	Date signed (mmm/dd/yyyy)

For Manulife use

Manulife customer number	Date (mmm/dd/yyyy)	Document version **297-1.5**

The personal information statement

Your consent to use your personal information

By signing this Application form, you give your consent for us to obtain, verify, and share your personal information, as set out below, in administering your account, now and in the future, with the plan sponsor, the plan administrator, the plan advisor and its employees and other parties in the performance of their duties for us.

You authorize us to use your Social Insurance Number (SIN) if applicable, to uniquely identify you during the administration of your account.

How we will maintain and use your personal information

You agree that we may use the personal information that we collect to:

- comply with legal and regulatory requirements,
- confirm your identity and the accuracy of the information you've provided,
- conduct searches to locate you and update your member information,
- administer this plan while you actively work for your employer, and after you no longer work with your employer,
- administer any other products and service that we provide to you, and
- determine your eligibility for, and provide you with details of, other select financial products or services that may be of interest to you that are offered by us, our affiliates or other select financial product providers.

Who may access your personal information

The following individuals may have access to your personal information:

- our employees and representatives who require this information to do their jobs,
- the plan advisor, including its employees, appointed by your Plan Sponsor to provide ongoing benefit counselling or plan administrative services,
- people to whom you have granted access,
- people who are legally authorized to view your personal information, and
- service providers who require this information to do their jobs.

This may include data processing, programming, printing, mailing, distribution, research and marketing or administration and investigation services.

Asking us not to use your personal information

You may withdraw your consent for us to use your SIN for non-tax administration purposes. You may also withdraw your consent for us to use your personal information to provide you with other product or service offerings, except those that are mailed with your statements.

If you wish to withdraw your consent for us to collect, use, retain or share your personal information, you may contact us by phoning our customer service centre at **1-888-727-7766** or by writing to the Privacy Officer at the address below.

How long we can keep your personal information

You authorize us to keep your personal information for the longer of:

- the time period required by law and by guidelines set for the financial services industry, and
- the time period required to administer the products and services we provide.

The information we collect with your consent will be protected and maintained in your Manulife plan member file.

The personal information that we must have

You may not withdraw your consent for us to collect, use, retain or share personal information that we need to issue or administer your account unless federal or provincial laws give you this right. If you do so, we may no longer be able to properly administer your account and this is what could happen:

- benefits will not be payable as provided under the plan,
- we may treat your withdrawal of consent as a request to terminate your contract, and
- your rights, and the rights of your beneficiary or estate under the plan may be limited.

Recording your customer service calls to us

We may record your customer service calls to us for the following reasons:

- quality service controls,
- information verification, and
- training.

If you do not wish to have your calls recorded, you must communicate with us in writing to Group Retirement Solutions, 25 Water Street South, Kitchener, ON N2G 4Y5, and request that any response by us also be in writing.

Questions, updates and requests for additional information

If you have a request, a concern, or wish to receive more information about our privacy policies, or if you wish to review your personal information in our files or correct any inaccuracies, you may contact us by sending a written request to: Privacy Officer, Group Retirement Solutions, 25 Water Street South, Kitchener ON N2G 4Y5.

Contact your plan advisor

Gregory Wyatt, Wyatt Insurance Corp.

☎ Call 604-533-9813

@ Send an email to greg@schmunkgattsmith.com

Questions?

Contact your plan advisor

Gregory Wyatt, Wyatt Insurance Corp.

☎ Call 604-533-9813

@ Send an email to greg@schmunkgattsmith.com

Contact Manulife

☎ Call **1-888-727-7766**

- Customer Service Representatives are available Monday to Friday from 8 a.m. to 8 p.m. ET
- Financial Education Specialists can be reached Monday to Friday from 9 a.m. to 5 p.m. ET

@ Send an email to GROmail@manulife.com

Visit **www.manulife.ca/GRO**

Use our TTY service at 1-866-391-7788.

Contact Manulife

☎ Call **1-888-727-7766**

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Manulife Financial
For your future

Manulife Financial

For your future™

Your Fund Selection Guide

Use this Guide, along with your **Enrolment Guide**, to understand the investments available through the Foursquare Gospel Church of Canada Registered Pension Plan.

About this Fund Selection Guide

This Guide explains the funds available to you through your company's Registered Pension Plan and helps you make investment choices suited to your needs.

Once you've selected your investments, please return to the Enrolment Guide to complete your enrolment.

If you have questions about your investments…

- You can contact your plan's advisor – Gregory Wyatt, Wyatt Insurance Corp. – for assistance with choosing your investments.

  ☎ Call 604-533-9813

  @ Send an email to greg@schmunkgattsmith.com

- You can also contact a Manulife Financial Education Specialist by calling **1-888-727-7766** from Monday to Friday between 9 a.m. and 5 p.m. ET.

Refer to the back cover of your **Enrolment Guide** for a card you can detach and keep in your wallet.

Determine what type of investor you are

To Do!

- ☐ Answer the questions below to determine whether you should build your own portfolio or select a single, ready-made fund.

	A	B
1. How interested are you in selecting investment funds for your retirement savings?	I have some interest. ☐	I am very interested. ☐
2. How likely are you to monitor and rebalance your investments on an annual basis?	I review my investments annually. ☐	I check my investments on a regular basis (at least quarterly). ☐
3. How would you rate your investment knowledge?	I understand the basics of investing. ☐	I am confident in my investment knowledge. ☐

If you chose two or more responses from...	The best investment strategy for you is...	Turn to page...
Column A	**...to select an Asset Allocation Fund.** Asset Allocation Funds offer a well-balanced portfolio inside a single fund, and a professional fund manager monitors and rebalances these portfolios for you. There is an Asset Allocation Fund that is suitable for you – whether you're a conservative investor or an aggressive one. 	**4**
Column B	**...to build your own portfolio.** Choose from the individual funds available through your program to build your own portfolio. 	**4**

Determine your investor style

To Do!

- ☐ Circle one answer for each question.
- ☐ Write your score – indicated in brackets at the end of each answer – in the box to the right of each question.
- ☐ Tally the scores you record for each question to get your total.

Your age, the numbers of years remaining until you retire, and how you feel about risk will determine your investor style. Once you know your investor style, you can choose funds for your retirement savings.

Your score

1. What is your investment horizon – when will you need this money?

- **a.** Within 3 years (0)
- **b.** 3-5 years (3)
- **c.** 6-10 years (5)
- **d.** 11-15 years (8)
- **e.** 15 + years (10)

2. What is your most important investment goal?

- **a.** To preserve your money (0)
- **b.** To see modest growth in your account (4)
- **c.** To see more significant growth in your account (7)
- **d.** To earn the highest return possible (10)

3. Please indicate which statement reflects your overall view of managing risk:

- **a.** I don't like risk and I am not prepared to expose my investments to any market fluctuations in order to earn higher long-term returns. (0)
- **b.** I am prepared to experience modest short-term market fluctuations in order to generate growth of capital. (2)
- **c.** I am prepared to experience average short-term market fluctuations in order to achieve a higher long-term return. (4)
- **d.** I want to maximize my long-term returns and am comfortable with significant short-term market fluctuations. (6)

4. **If you owned an investment that declined by 20% over a short period, what would you do?**

   a. Sell all of the remaining investment (0)

   b. Sell a portion of the remaining investment (2)

   c. Hold the investment and sell nothing (4)

   d. Buy more of the investment (6)

5. **If you could increase your chances of improving your investment returns by taking more risk, would you:**

   a. Be unlikely to take more risk (0)

   b. Be willing to take a little more risk with some of your portfolio (2)

   c. Be willing to take a lot more risk with some of your portfolio (4)

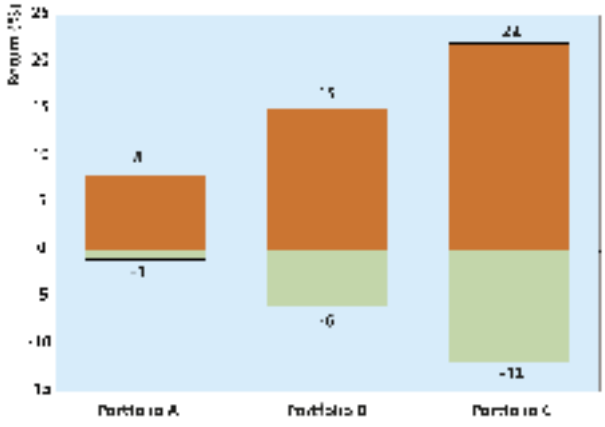
   d. Be willing to take a lot more risk with your entire portfolio (6)

6. **The following picture shows three model portfolios and the highest and lowest returns each is likely to earn in any given year. Which portfolio would you be most likely to hold?**

   a. Portfolio A (0)

   b. Portfolio B (3)

   c. Portfolio C (6)



7. **After several years of following your retirement plan, you review your progress and determine you are behind schedule and will need to modify your strategy in order to retire at your preferred age. What would you do?**

   a. Keep the same investments you currently hold, but increase your contributions as much as possible. (0)

   b. Slightly increase your exposure to riskier investments and slightly increase your contributions. (3)

   c. Move your entire portfolio to riskier investments, hoping to achieve the highest long-term return. (6)

8. Which statement best applies to your approach regarding achieving your retirement income goals on time?

a. I must achieve my financial goal by my target retirement date. (0)

b. I would like to come close to achieving my financial goal by my target retirement date. (2)

c. If I have not reached my financial goal by my target retirement date, I have the flexibility to delay my target retirement date. (4)

d. I re-evaluate my financial goals and target retirement date regularly and have the flexibility to adjust them to align with the performance of my investments. (6)

Your total score:

Match your score to an investor style below.

If your score is between...	Your investor style is...	About your investor style
0 – 7	Conservative	Protecting your money is your chief concern. You may be approaching retirement, or simply prefer to take a cautious approach to investing and preserve your money.
8 – 22	Moderate	You want your money to grow, but are more concerned about protecting it. Retirement may be in your near future or you may prefer to be cautious with your investments and preserve your money.
23 – 37	Balanced	You want a balance between growth and security although you will accept some risk to have the potential for higher returns over time.
38 – 48	Growth	You want to increase your money and are somewhat comfortable riding the ups and downs of the market in exchange for the possibility of higher returns over the long term. You may have time on your side until you retire.
49 – 56	Aggressive	You want to maximize the long-term growth of your retirement savings. You understand the ups and downs of the markets and are comfortable taking more risk to maximize potential returns. You have plenty of time to wait out market cycles until you retire.

My investor style is: _____

To Do!

If you are choosing...

...an Asset Allocation Fund

- ☐ Refer to page 8 for assistance with selecting the Asset Allocation Fund that is right for you.
- ☐ Decide if you want to invest a portion of your contributions in a fund that provides a guaranteeed income.
- ☐ Specify the 4-digit fund code for the fund(s) you select in the *Your investment instructions* section on each **Application form** and the percentage you want to invest in each.

...to build your own portfolio

- ☐ Refer to page 11 for assistance with selecting the investments that are right for you.
- ☐ Decide if you want to invest a portion of your contributions in a fund that provides a guaranteed income.
- ☐ Specify the percentage of contributions you want to invest in each fund in the *Your investment instructions* section on each **Application form**.

How to choose an Asset Allocation Fund

1 – Choose your Asset Allocation Fund

Your investor style (from page 6): _____

Choose the Asset Allocation (AA) Fund that matches your investor style.

If your investor style is...	The Asset Allocation Fund for you is...	Fund code
Conservative	ML Conservative AA	2001
Moderate	ML Moderate AA	2002
Balanced	ML Balanced AA	2003
Growth	ML Growth AA	2004
Aggressive	ML Aggressive AA	2005

Note – Although these funds are rebalanced periodically to ensure they meet the objectives for each investor style, we recommend you complete the Investor Style Questionnaire at least annually to ensure your style has not changed.

To see the **investment management fees** and **historical rates of returns** for these funds, turn to page 16 in this Guide. Please refer to the back of this Guide to obtain a detailed description of each Asset Allocation FundError: Reference source not found.

2 – Decide whether you would like to receive a guaranteed income

You can choose to direct a portion of your contributions into Manulife Group IncomePlus. Group IncomePlus offers you an opportunity to build guaranteed retirement income for life within your group retirement savings plan. When you're ready to receive income, Group IncomePlus will let you continue to benefit from equity market exposure while protecting your retirement income from market declines.

Group IncomePlus may suit your needs if:

- You want to diversify your sources of income at retirement,
- You are committed to long-term saving toward retirement,
- Your only other source of guaranteed retirement income will be provided by government benefit programs,
- You are risk averse and/or have a strong need or desire to guarantee an income under all circumstances,
- You are beginning to consider retirement or plan actively for retirement.

The Group IncomePlus fund available on your plan is the ML Group IncomePlus Bal. AA g4 (6203).

The Group IncomePlus Guarantee Fee is 0.45% per year. At $45.00 per $10,000 invested, Group IncomePlus offers an affordable guaranteed option.

Note: The investment performance of a market-based fund is not guaranteed.
If you are considering Group IncomePlus, please refer to the **The Bold Print** brochure for more detailed information about Manulife's Group IncomePlus.

3 – Complete each Application form

You need to indicate your investment choices in the section of the Application form titled *Complete if Asset Allocation Fund is your investment strategy*.

Percentage you decided to invest in a Manulife Group IncomePlus Fund: _____ %

- Write the above percentage beside the Group IncomePlus Fund on each form.

Percentage you decided to invest in a Manulife Asset Allocation Fund: _____ %

- The fund code for the Asset Allocation Fund you chose is: _____
- Write the above percentage and fund code on each form.

The above 2 percentages must add to 100%.

You have now finished the fund selection process. Please return to

Step four on page 9 of the **Enrolment Guide** to complete your enrolment.

How to build your own portfolio

1 – Find your sample portfolio

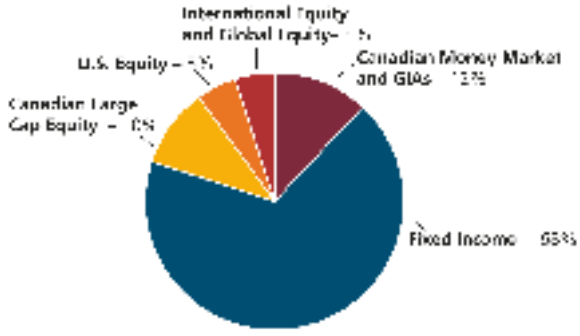
Your investor style (from page 6): _____

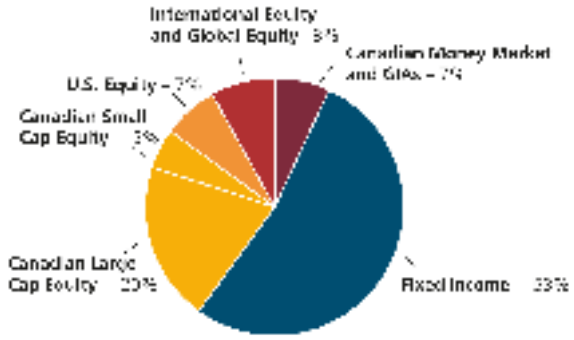
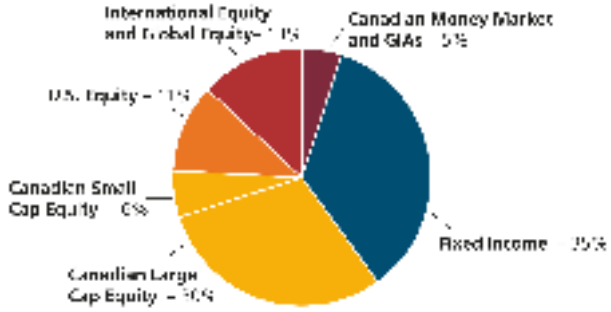
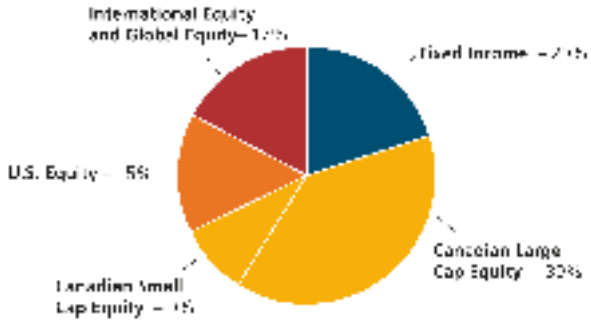
Find the sample portfolio that matches your investor style.

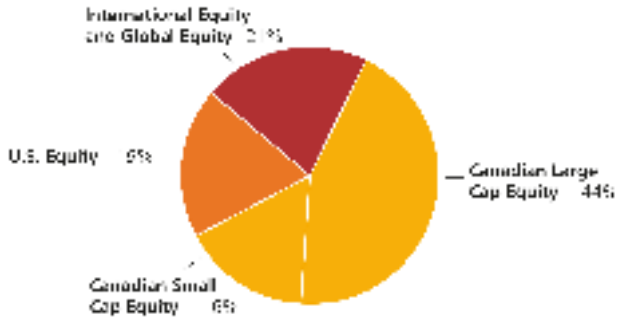
You can use the sample portfolios as a guideline to help you choose individual funds. To ensure you create a well-diversified portfolio, select at least one fund from each asset class.

Each asset class in the sample portfolio is represented by a different colour, and each fund's description is printed in the colour that represents its asset class. For example, all Fix Income fund descriptions are blue, and all US Equity fund descriptions are orange. Keep this in mind when researching and choosing funds to invest in.

You can find descriptions of all available funds at the back of this Guide.

If your investor style is...	A recommended asset mix for you is...
Conservative	

If your investor style is...	A recommended asset mix for you is...
Moderate	
Balanced	
Growth	

If your investor style is...	A recommended asset mix for you is...
Aggressive	

Notes:

- Balanced funds are **not** included in the sample portfolios. These funds are already well-diversified and generally invest 40% in fixed income investments and 60% in equity investments. Keep this in mind when you are using the guidelines shown.
- You should consider how your savings outside of this plan are invested. Your other investments may already fulfill some parts of the sample portfolio in the above table. The guidelines provided are only suggestions.

Where to find detailed fund information

A summary of the funds available through your group program – including the investment management fees and historical rates of return for these funds – is in the next section of this Guide titled *Your investment choices*. Please refer to the back of this Guide to obtain a detailed description of each fund.

2 – Decide whether you would like to receive a guaranteed income

You can choose to direct a portion of your contributions into Manulife Group IncomePlus. Group IncomePlus offers you an opportunity to build guaranteed retirement income for life within your group retirement savings plan. When you're ready to receive income, Group IncomePlus will let you continue to benefit from equity market exposure while protecting your retirement income from market declines.

Group IncomePlus may suit your needs if:

- You want to diversify your sources of income at retirement,
- You are committed to long-term saving toward retirement,

- Your only other source of guaranteed retirement income will be provided by government benefit programs,
- You are risk averse and/or have a strong need or desire to guarantee an income under all circumstances,
- You are beginning to consider retirement or plan actively for retirement.

The Group IncomePlus fund available on your plan is the ML Group IncomePlus Bal. AA g4 (6203).

The Group IncomePlus Guarantee Fee is 0.45% per year. At $45.00 per $10,000 invested, Group IncomePlus offers an affordable guaranteed option.

Note: The investment performance of a market-based fund is not guaranteed.
If you are considering Group IncomePlus, please refer to the **The Bold Print** brochure for more detailed information about Manulife's Group IncomePlus.

3 – Complete each Application form

You need to indicate your investment choices in the section of the Application form titled *Your investment instructions*.

You have now finished the fund selection process. Please return to Step four on page 9 of the **Enrolment Guide** to complete your enrolment.

Your investment choices

The remaining sections of this Guide include detailed information about the investments available in your program.

Funds available:

- Guaranteed Interest Accounts
- Group IncomePlus
- Asset Allocation
- Canadian Money Market
- Fixed Income
- Balanced
- Canadian Large Cap Eqty
- Cdn Small/Mid Cap Eqty
- US Large Cap Eqty
- International Equity
- Global Equity

Rates of Return Overview

Market-based Funds

The investments available through your plan appear here. The rates of return in this chart reflect performance before investment management fees (IMFs) are deducted.

Benchmark returns are also provided to help you compare fund performance. These returns, marked in *italics*, are for comparison purposes only and are not available for investment.

			Rates of return on October 31, 2014											
				Annualized Returns(%) [1]						Annual returns(%) [2]				
Fund Code	Fund Name	IMF% [3]	YTD [4]	1 Year	2 Year	3 Year	4 Year	5 Year	10 Year	2014	2013	2012	2011	2010
GROUP INCOMEPLUS														
6203	ML Group IncomePlus Bal. AA g4[5]	1.475	8.4	11.2	12.6	10.9	8.4	9.1	7.1	11.2	14.0	7.7	1.2	12.0
ASSET ALLOCATION														
2001	ML Conservative AA[5]	1.475	7.1	7.8	6.5	6.6	5.8	6.3	5.7	7.8	5.3	6.8	3.3	8.3
	Blend: MLI Conservative Asset Allocation		*6.3*	*6.7*	*5.2*	*5.3*	*5.0*	*5.6*	*5.4*	*6.7*	*3.8*	*5.3*	*4.0*	*8.0*
2002	ML Moderate AA[5]	1.475	7.7	9.4	9.5	8.8	7.0	7.6	6.3	9.4	9.6	7.3	1.8	9.9
	Blend: MLI Moderate Asset Allocation		*7.5*	*8.7*	*8.0*	*7.5*	*6.5*	*7.3*	*6.3*	*8.7*	*7.4*	*6.4*	*3.6*	*10.5*
2003	ML Balanced AA[5]	1.475	8.4	11.2	12.6	10.9	8.4	9.1	7.1	11.2	14.0	7.7	1.2	12.0
	Blend: MLI Balanced Asset Allocation		*8.2*	*10.4*	*10.8*	*9.4*	*7.6*	*8.4*	*6.8*	*10.4*	*11.3*	*6.7*	*2.3*	*11.8*
2004	ML Growth AA[5]	1.475	9.0	13.0	15.8	13.0	9.3	10.1	7.2	13.0	18.7	7.7	-1.1	13.4
	Blend: MLI Growth Asset Allocation		*9.0*	*12.2*	*13.7*	*11.4*	*8.7*	*9.5*	*7.4*	*12.2*	*15.3*	*6.9*	*0.9*	*13.0*
2005	ML Aggressive AA[5]	1.475	9.5	14.4	18.6	14.8	10.3	11.3	7.6	14.4	22.9	7.7	-2.2	15.4
	Blend: MLI Aggressive Asset Allocation		*9.9*	*14.1*	*16.7*	*13.4*	*9.8*	*10.6*	*7.8*	*14.1*	*19.4*	*7.1*	*-0.5*	*14.2*
CANADIAN MONEY MARKET														
3132	ML Cdn Money Market (MAM)	1.075	1.1	1.3	1.3	1.3	1.3	1.2	2.3	1.3	1.3	1.3	1.4	0.8
	FTSE TMX 91 Day Treasury Bill Index		*0.8*	*0.9*	*1.0*	*1.0*	*1.0*	*0.9*	*2.0*	*0.9*	*1.1*	*1.0*	*1.0*	*0.4*
FIXED INCOME														
4141	ML Fidelity Cdn Bond	1.825	6.9	6.3	3.2	4.4	4.8	5.5	5.8	6.3	0.3	6.8	5.9	8.4
4191	ML MAM Cdn Bond Index	1.075	6.6	5.9	2.9	3.8	4.3	5.0	5.3	5.9	-0.0	5.7	5.9	7.6
	FTSE TMX Universe Bond Total Return Idx		*6.5*	*5.8*	*2.8*	*3.8*	*4.3*	*5.0*	*5.3*	*5.8*	*-0.0*	*5.7*	*6.0*	*7.6*

Fund Code	Fund Name	IMF% [3]	YTD [4]	Rates of return on October 31, 2014 — Annualized Returns(%) [1] 1 Year	2 Year	3 Year	4 Year	5 Year	10 Year	Annual returns(%) [2] 2014	2013	2012	2011	2010
BALANCED														
5011	ML Balanced[5]	1.475	8.7	11.5	13.2	11.4	9.2	10.1	7.8	11.5	15.0	7.8	2.9	14.0
5181	ML Trimark Income Growth[5]	1.725	8.7	13.1	17.1	14.4	11.0	11.1	6.9	13.1	21.1	9.2	1.5	11.3
5241	ML JF Balanced[5]	1.425	9.1	12.9	14.9	13.2	10.4	10.1	7.4	12.9	16.9	9.9	2.5	8.5
5291	ML GEM Balanced[5]	1.375	10.0	12.3	12.0	10.5	8.1	8.6	n/a	12.3	11.8	7.5	1.1	10.7
5452	ML Mawer Canadian Balanced[6]	1.450	9.7	14.3	17.1	15.1	12.2	12.0	9.1	14.3	19.9	11.3	4.0	11.2
	Balanced Benchmark[8]		*7.9*	*9.9*	*10.0*	*8.6*	*6.9*	*7.7*	*6.4*	*9.9*	*10.0*	*6.0*	*2.1*	*10.9*
CANADIAN LARGE CAP EQTY														
7121	ML MAM Cdn Lrg Cap Growth	1.625	12.0	16.4	16.2	11.2	7.6	8.9	7.7	16.4	15.9	1.8	-2.5	14.2
7131	ML Cdn Lrg Cap Val (MAM)	1.575	8.6	11.1	17.8	14.0	8.7	10.2	8.4	11.1	24.9	6.8	-5.6	16.1
7132	ML MAM Cd Equity Index	1.075	10.1	12.8	11.9	9.4	6.7	9.1	8.1	12.8	11.0	4.4	-0.9	19.5
7141	ML Fidelity Cdn Large Cap[7]	1.825	8.2	12.7	25.8	19.1	19.0	19.3	15.1	12.7	40.3	6.7	18.7	20.6
7241	ML JF Canadian Equity	1.425	11.0	15.7	18.6	14.8	10.4	11.2	9.5	15.7	21.6	7.4	-1.8	14.3
	S&P/TSX Total Return		*9.9*	*12.6*	*11.8*	*9.3*	*6.7*	*9.1*	*8.0*	*12.6*	*11.0*	*4.5*	*-0.8*	*19.4*
CDN SMALL/MID CAP EQTY														
7381	ML FGP Small Cap Cdn Equity	1.425	7.6	13.9	21.7	17.5	12.6	15.0	12.0	13.9	30.1	9.4	-0.8	24.8
	BMO Nesbitt Burns Cdn Small Cap Index		*0.6*	*4.2*	*3.7*	*2.5*	*2.0*	*8.3*	*6.8*	*4.2*	*3.3*	*0.2*	*0.4*	*37.9*
US LARGE CAP EQTY														
8131	ML MAM U.S. Equity Index	1.075	17.4	26.3	29.3	24.5	19.3	17.3	7.0	26.3	32.2	15.5	5.0	9.8
8631	ML BG American Equity	1.625	18.5	27.3	30.4	25.8	20.5	17.9	9.6	27.3	33.4	17.2	5.7	7.8
	S&P 500 Composite Total Return Idx($Cdn)		*17.7*	*26.8*	*29.7*	*24.9*	*19.7*	*17.8*	*7.4*	*26.8*	*32.7*	*15.9*	*5.4*	*10.2*
INTERNATIONAL EQUITY														
8192	ML International Equity	1.775	2.2	7.4	22.0	16.3	10.2	8.9	5.5	7.4	38.6	5.8	-6.4	3.7
8321	ML BR Intl Equity Index	1.325	3.3	7.7	19.5	14.6	9.0	7.7	5.2	7.7	32.6	5.4	-6.1	2.5
8452	ML Mawer International Eqty	1.725	6.5	12.1	17.8	16.4	11.4	10.9	9.2	12.1	23.8	13.8	-2.6	9.5
	MSCI EAFE ($ Cdn)		*3.4*	*7.9*	*19.8*	*14.9*	*9.3*	*8.0*	*5.5*	*7.9*	*32.9*	*5.8*	*-6.0*	*2.9*
GLOBAL EQUITY														
8181	ML Trimark	1.725	8.5	16.0	22.1	18.9	15.3	13.7	7.5	16.0	28.5	12.9	5.0	7.6
	MSCI World ($ Cdn)		*11.3*	*18.1*	*24.8*	*20.0*	*14.6*	*13.0*	*6.7*	*18.1*	*32.0*	*10.8*	*-0.2*	*7.2*

Guaranteed Interest Accounts (GIAs)

The interest rates for the GIAs available through your plan appear here.

These rates are as at October 31, 2014.

Fund Code	Fund Name	Interest Rate
1001	Manulife 1 Year GIA	.900%
1003	Manulife 3 Year GIA	1.050%
1005	Manulife 5 Year GIA	1.350%

Notes:

[1] An annualized return is an average return that has been expressed as an annual (yearly) rate.

[2] An annual return is the return of an investment over a 12 month period. As an example: a one year annual return as at June 30, 2012 would be from July 1, 2011 to June 30, 2012.

[3] The Investment Management Fees (IMFs) shown incorporate costs related to investment management services, record-keeping, administration and segregated fund operating expenses, and may include underlying fund operating expenses. Applicable taxes are not included in the IMFs.

[4] Year to date (YTD) rates of return are not annualized.

[5] Refer to the fund page for details on how the benchmark is comprised.

[6] Effective April 2012, the underlying fund changed from the Mawer Canadian Balanced RSP to the Mawer Canadian Balanced Pooled fund. For the Manulife Segregated Fund, performance prior to this date was derived from the Manulife Mawer Canadian Balanced RSP.

[7] The Fund is invested in a mixture of Canadian and foreign securities.

[8] Comprised of 35% S&P/TSX Composite Index, 35% DEX Universe Bond Index (Total Return), 10% S&P 500 Index ($C), 10% MSCI EAFE Index ($C), and 10% DEX 91-Day T-bills.

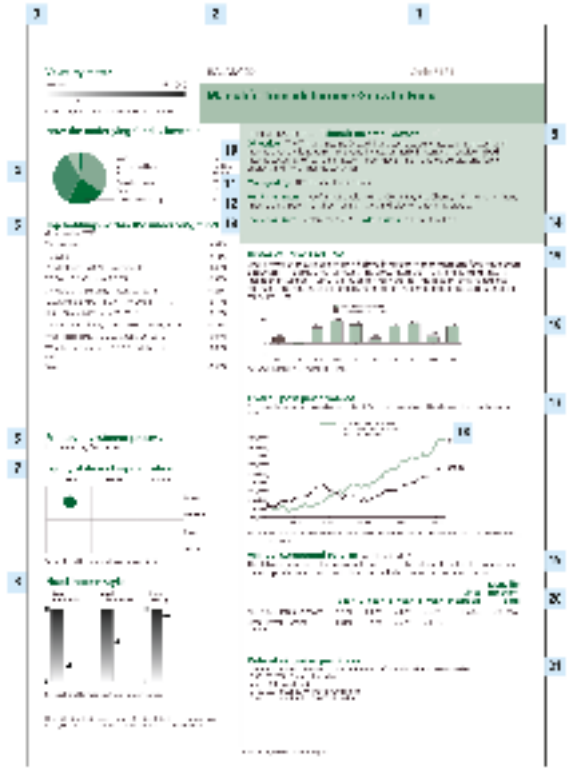
Manulife Return

These numbers represent the gross rate of return of the Manulife fund.

Additional Historical Information

In order to provide further historical information, we have included the returns of the underlying funds.

How to Read Fund Descriptions



1 Fund code

Each fund is named using a unique code. Identify a specific fund using its fund code when you select or change funds.

2 Asset class

The types of investments (such as Canadian Equity, International Equity, Fixed Income) that account for the majority of the fund's holdings. Funds are colour-coded by asset class.

Please note: Funds classified as "Balanced" hold similar portions of equity and fixed income investments.

3 Volatility meter

The volatility meter is a scale – ranging from low to high – that illustrates the amount that a fund's value is likely to fluctuate. Fund volatility is based on the standard deviation of monthly returns over a three-year period. Funds in operation for less than three years are rated using the longest time period available.

For a new fund where no history is available, the standard deviation of the fund's asset class is displayed. The current volatility meter (in use after June 2007) uses a 25-point volatility scale.

Generally, the greater the return you hope to realize with a fund, the greater the risk you must be prepared to take. Funds with high volatility tend to show more dramatic fluctuations on a monthly basis over time.

4 How the underlying fund is invested

The pie chart shows the types of investments in the underlying fund and the percentage of the overall portfolio they represent.

5 Top holdings

The individual investments in the underlying fund that comprise the largest percentage of the overall portfolio. This is determined using the percentage weighting of the fund's net market value.

6 Primary investment process

Fund managers use a number of approaches to determine the asset allocation of a fund and to select the individual securities it will hold. These are the most common approaches:

- **Fundamental Bottom-up** – This approach considers the investment merits of individual companies. The sector allocation of a fund managed in this way will be determined by the individual stocks held in the fund.
- **Fundamental Top-down** – Managers who use this approach focus on the economy and financial markets. Once this broad view – also known as a macro view – is determined, managers choose individual stocks from sectors they expect to outperform the market.
- **Quantitative** – This technique applies complex mathematical research and statistical models along with measurement and research to identify attractive investments.
- **Index** – An indexed portfolio is constructed to mimic the performance of a specific market index. This approach is also known as passive investing.

- **Multi-manager** – A multi-manager fund is directed by more than one investment manager and often combines different investment styles or asset classes.

7 **Equity style and capitalization**

This chart displays the primary equity investment style (such as value or growth) the fund manager uses to select securities as well as the 'market capitalization' of securities in the fund. Market capitalization is a term used to define the total market value of a particular company's outstanding shares. In the context of an investment fund, this term refers to the size of the companies whose stocks are held in the fund. This term only applies to funds with equity – or stock – holdings.

8 **Fixed income Style**

This chart shows the different approaches a manager uses to select fixed income holdings within the portfolio.

9 **Underlying fund**

Market-based investment options available to group plans are usually fund-on-fund investments which invest in existing pooled funds or mutual funds. These are known as the underlying funds. When a contribution is made to a Manulife fund, it's used to purchase units of the corresponding underlying fund. For example, contributions to the Manulife Trimark Income Growth Fund purchase units of the Trimark Income Growth Fund.

Each Manulife fund may hold a small cash component, and the underlying fund may do the same. A fund-on-fund strategy seeks to produce similar returns to the underlying fund within the Manulife fund.

10 **Objective**

The fund's primary investment goal(s) as determined by the fund manager.

11 **Managed by**

This names the investment management firm who oversees the fund.

12 **Fund managers**

The name of the lead fund manager(s) accountable for investment decisions in the underlying fund.

13 **Inception date**

The date the underlying fund was first available for purchase.

14 **Total assets**

The total market value of all assets invested in the underlying fund on a specific date.

15 **Historical gross returns**

The performance of the fund over a specified period. Performance histories are shown for illustrative purposes; they are not a guarantee of future performance. Unit values fluctuate with the market value of the underlying fund's assets. Gross returns mean the rates of return before investment management fees (IMFs) and Goods and Services Tax (GST) are deducted.

An individual who invests in the fund earns a net return after fees. Management fees vary by firm and by plan. Returns shown here represent results for the Manulife fund and/or its underlying fund.

16 **Year by year returns**

This shows the one-year return of the fund during each year illustrated in the accompanying graph.

17 **Overall past performance**

This graph shows how a $10,000 investment in the fund changed in value over a specified period, and the value of that investment at the end of the period. It also compares the value of that investment with the value of the same investment in a related, broadly-based index.

18 **Index**

A broadly-based market view offered for comparative purposes. It is not necessarily the fund's benchmark (an index a fund is measured against) as the fund's investment style may differ from the one applied to the benchmark.

19 **Annual compound returns**

Returns for a specified period expressed as an annualized rate.

20 **Manulife inception date**

The first full month the fund was available to Manulife Group Retirement Solutions plans.

21 **Rate of return expectation**

The benchmark whose performance the fund manager expects to meet or exceed over the long term. Investments held in this benchmark are indicative of the investments held in the fund.

Manulife Financial

For your future™

Change form

Send your completed form to:
Manulife Financial
Attn: GRS Client Services, KC-6
PO BOX 396 STN WATERLOO
WATERLOO, ON N2J 4A9

Please print clearly in the blank boxes. Remember to sign and date the form.

This form is also available on the Manulife Web site at www.manulife.ca/GRO

Section 1

Complete only the sections relevant to the change you are making.
Indicate the type of change you would like to make.

- ☐ Name change - complete sections 1, 2, 3 and 7
- ☐ Beneficiary change - complete sections 1, 2, 4, and 7
- ☐ Address change - complete sections 1, 2, 5 and 7
- ☐ Other change - complete sections 1, 2, 6 and 7

Section 2

Your personal information

If you do not know your member number, your Plan Administrator will provide it. Please use the member name currently on our records when submitting a name change.

Must be fully completed

Plan Sponsor/Employer		Group policy number
Foursquare Gospel Church of Canada		10000971
Member number	Customer number	
Last name of member (as listed currently)	First name	Middle initial

Section 3

Your change of name

Last name of member	First name	Middle initial
Witness/Plan Administrator's signature		Date signed (mmm/dd/yyyy)

Section 4

*A **revocable** beneficiary can be changed at anytime.*

*An **irrevocable** beneficiary can only be changed with written consent from that beneficiary. You will also need your beneficiary's consent to withdraw or transfer money from your account. A parent or guardian cannot provide consent on behalf of a minor who has been named as irrevocable beneficiary.*

If you want to name more than three beneficiaries, attach a separate page with the names and the percentage of proceeds for each beneficiary.

If you have locked-in money in your RSP and you have a spouse on the date of your death, the law may require any death benefit be paid to your spouse, regardless of other beneficiaries you've named.

If you die while your beneficiary is still a minor, the trustee you name on this form will act on the child's behalf.

Your change of beneficiary (or beneficiaries)

If you do not name a beneficiary, proceeds will be paid to your estate.

☐ Check here if you have attached a separate page listing additional beneficiaries. Please sign and date the attachment.

Name	Relationship	Percentage of proceeds
		%
		%
		%
	Total must equal 100%	**100%**

The above beneficiary designations are considered revocable unless you write "irrevocable" in the chart above.

For Quebec only:
The designation of a spouse as a beneficiary is deemed to be irrevocable unless specified here: ☐ Revocable

Trustee for a minor beneficiary named above (not applicable in Quebec)
Any payment to a beneficiary who is a minor will be paid in trust to the trustee named below.
In Quebec, the proceeds will be paid in trust to the minor child's tutor.

Trustee name	Relationship

As current irrevocable beneficiary, I hereby consent to the change in beneficiary indicated in Section 4.

Irrevocable beneficiary's signature (if required)	Date signed (mmm/dd/yyyy)

Section 5

Your change of contact information

Mailing address (number, street and apt. number)				
City	Province	Postal code	Telephone number	Ext
Email				

Section 6

Other changes

Section 7

You must sign to authorize ANY of the above changes.

Please sign here

Member's signature	Date signed (mmm/dd/yyyy)

Manulife Financial

For your future℠

Withdrawal form

Please print clearly in the blank boxes.

Use this form for cash withdrawals, transfer of funds to an individual or group plan with Manulife Financial or transfer of funds to another financial institution. To terminate membership in the plan, use form GP0765. If you belong to more than one plan, complete a separate form for each plan.

Your personal information

Plan Sponsor/Employer				Group Policy number
Foursquare Gospel Church of Canada				10000971
Member number				Customer number
Last name			First name	Middle initial
Mailing address (number, street and apartment number)			Telephone number*	Ext.*
City	Province	Country	Postal Code	Email address*

These fields are optional.

Your withdrawal type

Note: Tax may be deducted and/or a market value adjustment, and/or a service charge applied if applicable. Not all withdrawal types may be available under your plan. See your Plan Administrator for details.

- ☐ Transfer to an individual or group plan with Manulife Financial
- ☐ Transfer to another financial institution
- ☐ Cash withdrawal

Your withdrawal amount

☐ Full withdrawal of all funds
Are future contributions going to continue?
☐ Yes ☐ No
(If No, member status will be changed to inactive)

☐ Partial withdrawal amount
Must equal total amount shown in fields below.

Gross dollar amount
$

Include Group IncomePlus investments in the withdrawal request: ☐ Yes ☐ No

If you do not make a selection, no money will be withdrawn from Group IncomePlus.

If you selected 'Yes' and withdraw funds from Group IncomePlus, your withdrawal will reduce your Guaranteed Benefit Base and the Guaranteed Annual Income Amount it will provide. If the amount of the withdrawal is more than your Guaranteed Benefit Base, a Freeze Period will begin. You will not be able to make any Occasional Contributions to Group IncomePlus until this period concludes. Before you withdraw from Group IncomePlus, learn more by logging into your account at www.manulife.ca/GRO

Optional: You can choose which investments you want to withdraw from.

Investment code	Amount to be withdrawn $	Investment code	Amount to be withdrawn $
Investment code	Amount to be withdrawn $	Investment code	Amount to be withdrawn $

Your transfer information

Please ensure any appropriate transfer forms are attached.

What type of plan are the funds being transferred to?

☐ RRSP / LIRA	Policy Number	☐ Pension Plan	Policy Number
☐ Annuity	Policy Number	☐ RRIF / LIF / LRIF	Policy Number
☐ TFSA	Policy Number	☐ Non-Registered	Policy Number

Name of new financial institution

Mailing address (number, street and suite number)

City	Province	Postal Code

Your payment method

FOR CASH WITHDRAWALS ONLY

Direct deposit is available only to Canadian currency bank accounts.

1 ▶ ☐ **Direct Deposit**

Bank Name

Transit Number	Institution Number	Account Number

2 ▶ ☐ **Cheque**

Specify where cheque should be mailed:

- ☐ Plan Administrator
- ☐ Member's address (shown above)
- ☐ Other (specify)_____

_____

_____

_____

Please sign here

I understand that I have made a selection from the withdrawal options listed and I require no further information on these options. Where locked-in funds are being transferred, I agree that they will be administered in accordance with applicable legislation.

By withdrawing my funds in cash (where available), I acknowledge that these funds may be subject to income tax withholding, fees or market value adjustment. I hereby certify that the information on this form is correct to the best of my knowledge.

If I am withdrawing Group IncomePlus investments, I understand that this transaction will affect my Group IncomePlus benefits.

Your signature	Date signed (dd/mmm/yyyy)
Irrevocable beneficiary's signature (if required)	Date signed (dd/mmm/yyyy)
Plan Administrator's signature (if required)	Date signed (dd/mmm/yyyy)

Mailing instructions

Send your completed forms to the address below.

If you live outside of Quebec:

Manulife Financial
Attn: GRS Client Services
P.O. Box 396
Waterloo, ON N2J 4A9

If you live in Quebec:

Manulife Financial
Group Retirement Solutions
2000 Mansfield, Suite 1410
Montréal, QC H3A 3A2

Manulife Financial

For your future℠

Notice of Death

Please print clearly in the blank boxes.

- **If member belongs to more than one plan, complete a separate form for each plan.**
- **Please submit this form with the last contribution for the member.**

To be completed by Plan Sponsor/Employer

*In some jurisdictions, the Spouse **MUST** receive the pension/locked-in RRSP death benefits. (See definitions of Spouse on reverse.)*

Plan Sponsor/Employer			Group policy number
Foursquare Gospel Church of Canada			10000971
Last name of deceased member	First name	Middle initial	Member number
Date of death (dd/mmm/yyyy)	**Please indicate the last day for which contributions have been made. Do not submit this form until the final contribution is submitted.**		Date (dd/mmm/yyyy)
Name of spouse (last, first and middle initial). Please see page 2 for provincial pension legislation definitions of spouse (for pension/locked-in RRSP only).			☐ The deceased member does not have a spouse

To be completed by beneficiary

(Note: Certified copies provided by the Plan Administrator are acceptable for claims < $150,000. Original documents will be returned upon settlement if requested).

Name of beneficiary (last, first and middle initial)			Relationship to member
Address			Beneficiary birthdate (dd/mmm/yyyy)
City	Province	Postal code	S.I.N.

Proof of Death requirements

☐ Attach Funeral Director's statement

If claim is for more than $150,000.00 attach Death Certificate

Please sign here

I hereby certify that the information on this form is correct to the best of my knowledge.

Signature of beneficiary	Date signed (dd/mmm/yyyy)

I hereby certify that the above information provided from plan records is correct.

Signature of Plan Administrator	Date signed (dd/mmm/yyyy)

Mailing instructions

Send your completed forms to the address below.

If you live outside of Quebec:

Manulife Financial
Attn: GRS Client Services
P.O. Box 396
Waterloo, ON N2J 4A9

If you live in Quebec:

Manulife Financial
Group Retirement Solutions
2000 Mansfield, Suite 1410
Montréal, QC H3A 3A2

DEFINITION OF SPOUSE (Subject to Change)

ALBERTA "pension partner" means, in relation to another person,

(a) a person who, at the relevant time, was married to that other person and had not living separate and apart from that other person for 3 or more consecutive years,or

(b) if there is no person to whom subclause (a) applies, a person who, immediately preceding the relevant time, had lived with that other person in a conjugal relationship

(i) for a continuous period of at least 3 years, or

(ii) of some permanence, if there is a child of the relationship by birth or adoption.

BRITISH COLUMBIA "spouse" means in relation to another person,

(a) a person who at the relevant time was married to that other person, and who, if living separate and apart from that other person at the relevant time, did not live separate and apart from that other person for longer than the 2 year period immediately preceding that relevant time, or

(b) if paragraph (a) does not apply, a person who was living and cohabiting with that other person in a marriage-like relationship, including a marriage-like relationship between persons of the same gender, and who had been living and cohabiting in that relationship for a period of at least 2 years immediately preceding the relevant time.

MANITOBA legally married or "common-law partner" of a member of former member means

(a) a person who, with the member or former member, registered a common-law relationship under section 13.1 of The Vital Statistics Act, or

(b) a person who, not being married to the member or former member, cohabited with him or her in a conjugal relationship

(i) for a period of at least three years, if either of them is married, or

(ii) for a period of at least one year, if neither of them is married.

NEW BRUNSWICK "spouse" means either of two persons who

(a)are married to each other,

(b)are married to each other by a marriage that is voidable and has not been avoided by a declaration of nullity, or

(c)have gone through a form of marriage with each other in good faith that is void and have cohabited within the preceding year,

"common-law partner" means

(a)in the case of the death of a member or former member, a person who, not being married to the member, was cohabiting in a conjugal relationship with the member or former member at the time of death of the member of former member and was cohabiting in a conjugal relationship with the member or former member for a continuous period of at least two years immediately before the death of the member or former member,

(b)in the case of the breakdown of the common-law partnership, a person who, not being married to the member or former member, was cohabiting in a conjugal relationship with the member or former member for a continuous period of at least two years immediately before the date of the breakdown of the common-law partnership, or

(c) in any other case, a person who, not being married to a member or former member at the particular time under consideration, is cohabiting in a conjugal relationship with the member or former member at that time and who has so cohabited for a continuous period of at least two years immediately before that time;

NEWFOUNDLAND "spouse" means, a person who

(a) is married to the member or former member,

(b) is married to the member or the former member by a marriage that is voidable and has not been voided by a judgement of nullity, or

(c) has gone through a form of marriage with the member or former member, in good faith, that is void and is cohabiting or has cohabited with the member or former member within the preceding year.

"cohabiting partner" means

(a) in relation to a member or former member who has a spouse, means a person who is not the spouse of the member or former member who has cohabited continuously with the member or former member in a conjugal relationship for not less than 3 years, or

(b) in relation to a member or former member who does not have a spouse, means a person who has cohabited continuously with the member or former member in a conjugal relationship for not less than 1 year,
and is cohabiting or has cohabited with the member or former member within the preceeding year.

NOVA SCOTIA "spouse" means either of a man and a woman who

(a) are married to each other

(b) are married to each other by a marriage that is voidable and has not been annulled by a declaration of nullity, or

(c) have gone through a form of marriage with each other, in good faith, that is void and are cohabiting or, if they have ceased to cohabit, have cohabited within the twelve-month period immediately preceding the date of entitlement;

"common-law partner" of an individual means

(a) another individual who has cohabited with the individual in a conjugal relationship for a period of at least two years, neither of them being a spouse.

ONTARIO Pension Benefits Act, - "Spouse" means either of two persons who,

(a) are married to each other, or

(b) are not married to each other and are living together in a conjugal relationship,

(i) continuously for a period of not less than three years, or

(ii) in a relationship of some permanence, if they are the natural or adoptive parents of a child, both as defined in the Family LawAct.

NOTE: The Ontario Human Rights Commission recognizes spouses of the same sex.

PRINCE EDWARD ISLAND Pension Benefits Act - Determined in accordance with the Plan Document

QUEBEC "Spouse"

(a) is married to or in a civil union with the member;

(b) has been living in a conjugal relationship with a member who is neither married nor in a civil union, whether the person is of the opposite or the same sex, for a period of not less than three years, or for a period of not less than one year.

- at least one child is born, or to be born, of their union;
- they have adopted, jointly, at least one child while living together in a conjugal relationship; or
- one of them has adopted at least one child who is the child of the other, while living together in a conjugal relationship.

SASKATCHEWAN "spouse" means

(a) a person who is married to a member or former member; or

(b) if a member or former member is not married, a person with whom the member or former member is cohabiting as spouses at the relevant time and who has been cohabiting continuously with the member or former member as his/her spouse for at least one year prior to the relevant time (S.S. 2001, c. 50, s. 12(2).).

OSFI Pension Benefits Standards Act, 1985 (applies to employees in the Northwest Territories, Yukon, Nunavut, and of federally regulated Employers.

"Spouse"

A spouse means in relation to another person:

a) If there is no person described in paragraph b), a person who is married to that other person or who is party to a void marriage with that other person, or

b) A person who is cohabitating with that other person in a conjugal relationship at the date of entitlement, having so cohabitated with that other person for at least one year.

Manulife Financial

Please print clearly in the blank boxes.

- **Please submit this form along with the last contribution for the terminating member.**
- **If employee is a member of more than one plan, complete a separate form for each plan.**
- **This form is also available on the Manulife Web site at www.manulife.ca/GRO**

IF TERMINATION IS DUE TO DEATH – COMPLETE ONLY "NOTICE OF DEATH" FORM NUMBER GP0770E

Termination form

Send your completed form to:
Manulife Financial
Attn: GSRS Client Services, KC-6
PO BOX 396 STN WATERLOO
WATERLOO, ON N2J 4A9

Your personal information

Plan Sponsor/Employer				Group Policy number	
Foursquare Gospel Church of Canada				10000971	
Member number			Customer number		
Last name		First name		Middle initial	
Mailing address (number, street and apartment number)					
City	Province	Country	Postal Code	Telephone number*	Ext*

These fields are optional.

Your reason for termination

1. What is the reason for termination?
2. When was the last date of employment?

Please Check One ☐ Termination of employment ☐ Early retirement ☐ Normal retirement ☐ Termination of employment due to disability

Last date of employment (dd/mmm/yyyy) *Please indicate at right the last month for which this member contributed. Do not send this form until the final contribution is submitted.* (mmm/yyyy)

Your option request

If you have assets invested in Group IncomePlus, please note to preserve your Guaranteed Benefit Base and your guaranteed retirement income with your Group IncomePlus investments, you must elect option 1 or 2. Selecting option 3,4 or 5 voids all Group IncomePlus income guarantees. For more information, please review The Bold Print.

NOTE: A withdrawal may have tax deducted and/or a market value adjustment, and/or a service charge applied, if applicable. See your Plan Administrator for details.

☐ 1. Transfer to Manulife Group Personal Plans RSP or Savings Account, complete page 2.
☐ 2. Transfer to Manulife Financial Group Retirement Income Plan (Complete separate application form GP4931.)
☐ 3. Cash (not available if funds are locked-in)
☐ 4. Transfer to an individual plan with Manulife Financial*
☐ 5. Transfer to another financial institution*

*If you select option 4 or 5, please complete Transfer information section below.

Your transfer information

(Please ensure any appropriate transfer forms are attached.)

If the funds are being transferred outside Manulife Financial

What type of plan are the funds being transferred to?

☐ RRSP / LIRA Policy no._____ ☐ RRIF / LIF / LRIF /PRIF Policy no._____
☐ Annuity Policy no._____ ☐ Non-Registered Policy no._____ ☐ Pension Plan Policy no._____

Name of new financial institution		
Mailing address (number, street and suite number)		
City	Province	Postal Code

Where should the cheque(s) be mailed?

☐ Address of new financial institution ☐ Plan Administrator ☐ Member's address as shown above ☐ Other

Please sign here

I understand that I have made a selection from the termination options listed and I require no further information on these options. Where locked-in funds are being transferred, I agree that they will be administered in accordance with applicable legislation. By withdrawing my funds (where available), I acknowledge that these funds may be subject to income tax withholding, fees or market value adjustment. I hereby certify that the information on this form is correct to the best of my knowledge.

I acknowledge the selection of option 3,4 or 5 above will result in voiding all Group IncomePlus income guarantees. If I have Group IncomePlus assets and have selected option 1 or 2 above, I acknowledge that I have read and understood The Bold Print and by signing below, I agree to the terms, conditions and fees applicable to that option.

Your signature	Date signed (mmm/dd/yyyy)
Irrevocable beneficiary's signature (if required)	Date signed (mmm/dd/yyyy)
Plan Administrator's signature (if required)	Date signed (mmm/dd/yyyy)

Manulife Financial

Transfer to Manulife Group Personal Registered or Non-Registered Savings Plan

Please print clearly in the blank boxes.

- **Complete only if you have selected this option on the reverse.**

Send your completed form to:
Manulife Financial
Attn: GSRS Client Services, KC-6
PO BOX 396 STN WATERLOO
WATERLOO, ON N2J 4A9

Your authorization

If my current assets are registered, I request that Manulife Financial enrol me as a member in the Plan and register me in a RetirementSavings Plan under the Income Tax Act (Canada) and (for Quebec registration only) a Retirement Savings Plan under and for thepurpose of applicable regulations in respect of the Taxation Act (Quebec).

I understand that an investment direction will be established as per my current plan, unless otherwise specified.

If applicable, I hereby request that Manulife Financial accept the transfer of my locked-in pension funds into the Plan in accordancewith the supplementary Locked-in Retirement Account agreement or locking-in addendum. With respect to such funds, I understandthat terms of the Locked-in Retirement Account agreement or locking-in addendum will override the terms of the Group RetirementSavings Plan contract, where applicable.

Name your beneficiary (or beneficiaries)

*A **revocable** beneficiary can be changed at anytime.*

*An **irrevocable** beneficiary can only be changed with written consent from that beneficiary. You will also need your beneficary's consent to withdraw or transfer money from your account.*

If you want to name more than three beneficiaries, attach a separate page with the names and the percentage of proceeds for each beneficiary.

If you have locked-in money in your RSP and you have a spouse on the date of your death, the law may require any death benefit be paid to your spouse, regardless of other beneficiaries you've named.

If you die while your beneficiary is still a minor, the trustee you name on this form will act on the child's behalf.

If you do not name a beneficiary, proceeds will be paid to your estate.

☐ Check here if you have attached a separate page listing your beneficiaries. Please sign and date.

Name	Relationship	Percentage of proceeds

The above beneficiary designations are considered revocable (if you live outside of Quebec).

For Quebec only:
The designation of a spouse as a beneficiary is deemed to be irrevocable unless specified here: ☐ Revocable

Trustee for a minor beneficiary named above (not applicable in Quebec)
Any payment to a beneficiary who is a minor will be paid in trust to the trustee named below.

In Quebec, the proceeds will be paid in trust to the minor child's tutor.

Trustee name	Relationship

Please sign here

I confirm that I have read the Manulife Personal Plans brochure and understand and agree to the terms that will apply to thisplan/account. I hereby certify that the information on this form is correct to the best of my knowledge.

If I have selected Group IncomePlus, I acknowledge that I have read and understood The Bold Print and by signing below, I agree to the terms, conditions and fees applicable to that option.

Your signature	Date signed (mmm/dd/yyyy)
Plan Administrator's signature (if required)	Date signed (mmm/dd/yyyy)

Your Waiver of Participation Form

For: Foursquare Gospel Church of Canada

Foursquare Gospel Church of Canada
Rhonda Berkhiem
B307 - 2099 Lougheed Highway, Port Coquitlam,
BC, V3B 1A8

Please print clearly in the blank boxes.

Your personal information

First name	Middle Initial	Last name
Date of birth (mmm/dd/yyyy)		Foursquare

For your RPP (Policy number 10000971)

Your waiver of participation

Check the box if you do not want to participate in this plan.

☐ I acknowledge that I have been given the opportunity to participate in the the Foursquare Gospel Church of Canada RPP. I wish to decline to participate in the plan at this time and agree to waive any and all liability to the corporation and its successors and/or affiliated associated companies in this regard.

Please sign here

Your signature	Date Signed (mmm/dd/yyyy)

GROUP INSURANCE PLAN

CONTACT INFORMATION

MANULIFE CUSTOMER SERVICE SUPPORT 1-800-268-6195

All forms for Health & Dental claims should be forwarded directly to:

MANULIFE FINANCIAL HEALTH CLAIMS
PO BOX 1653 WATERLOO, ON N2J 4W1

MANULIFE FINANCIAL DENTAL CLAIMS
PO BOX 1654 WATERLOO, ON N2J 4W2

MANULIFE GROUP BENEFITS- ATTENTION: DISABILITY CLAIMS
PO BOX 400 STN PLACE-D'ARMES, MONTREAL, QC H2Y 3H1

REPRESENTATIVE: Questions on Group Plan coverage can be addressed to:

Greg Wyatt
Schmunk, Gatt, Smith & Associates
Suite 204 – 20334 56th Avenue
Langley, BC V3A 3Y7
(604) 533-9813

TABLE OF CONTENTS

GROUP INSURANCE PLAN

TYPE OF PLAN

All benefits (Life Insurance, Extended Health, Dental, AD&D and Long-Term Disability) are underwritten by MANULIFE FINANCIAL.

Policyholder Name: Foursquare Gospel Church of Canada, **Policy #**0632057**, Division #**001

EMPLOYEE ENROLLMENT REQUIREMENTS

It is the employer's responsibility to ensure that an employee's application form is completed and submitted to the FBP Administrator at **least 30 days prior to the eligible date – which is three months after start of employment.** Income reported on enrollment will include salary and allowances (car, clergy residence deduction, etc.) but does not include overtime or bonus.

All employees are eligible provided they are working 20 hours per week or more and have completed three (3) months of continuous service. An employee is defined as a person earning at least $2,000 per month.

Employees that are paid less than $2,000, including benefits, may choose to participate on a voluntary basis, on agreement by pastor and church council. Please send the National Office a signed letter by the Council for voluntary participation or if they wish to waive the 3 month wait time.

EFFECTIVE DATE OF EMPLOYMENT COVERAGE

Your coverage will become effective after the waiting period has been completed, provided application for benefits has been made within 31 days after the end of the 3 month waiting period. Application made after that date means you are a late applicant with restricted coverage.

If you are not actively at work on the day you would normally become eligible, you will become eligible upon return to full-time employment.

Evidence of insurability is required when:

1. You are a late applicant for any benefit (you did not apply during the 31 days eligibility period but requested coverage at a later date);
2. You apply for coverage in excess of the non-medical evidence limit.

GROUP INSURANCE PLAN

ENROLLMENT

Each eligible employee must complete an APPLICATION FORM and designate a beneficiary for life insurance. See APPENDIX C for forms.

In order to avoid late registration it is recommended that the employer have the employee complete all forms when commencing employment and forward them to the FBP Administrator for processing.

If the employee is covered under a spouse's plan, **it is recommended that the employee still enroll in the life insurance portion of the benefits with Manulife Financial**. In the event the spouse is no longer covered under the plan, the employee will then not be required to apply as a late entrant with proof of insurability.

CHANGE OF INFORMATION

Whenever there is a change in salary, name change, address, or change in beneficiary, a CHANGE FORM should be sent to FBP Administrator, in order to ensure that the employee is receiving proper entitled coverage. See APPENDIX C for forms.

CERTIFICATE OF INSURANCE

The Insurance Company will confirm the enrollment of an employee in the GIP by issuing a Certificate of Insurance. New certificates will be issued whenever a change is required.

CLAIMS

All claims should be reported as soon as possible after the date of the loss or the date of the expense is incurred.
For making online claims please register for the Plan Member Secure site.
(**www.manulife.ca/groupbenefits/planmember**)
For detailed information and the necessary claim forms for the benefits being claimed, please see APPENDIX C and/or contact your FBP Administrator.

NOTE: Time limitations may apply for benefits.

GROUP INSURANCE PLAN

MONTHLY PAYMENTS

On receipt of an APPLICATION FORM, the FBP Administrator will calculate the required monthly premium and then advise the employer of the amount to deduct from salary and the amount to be paid by the employer. **Our agreement calls for half of the premium to be deducted from salary and half to be paid by the employer.**

Premiums for the entire Group are invoiced by Standard Life to the FBP Administrator for full months and are billed and payable for the current month. An invoice for each plan member will be sent to the church for premiums billed for the month.

If premiums are not paid within the specified time, the employer is jeopardizing the coverage of the employee and this may place the employer in a position of liability with the employee and/or their dependents or beneficiaries.

The monthly contributions are forwarded to the FBP Administrator by cheque, made payable to the FOURSQUARE BENEFIT PLAN or Electronic Bill Payment. Many churches have employees participating in both the Pension Plan and Group Insurance Plan. All payments can be included in one monthly cheque or electronic submission with an attached DISTRIBUTION FORM. A copy of the MONTHLY PAYMENT DISTRIBUTION FORM is included in Appendix A of the manual and should be photocopied as needed.

LONG TERM DISABILITY POLICY

The Foursquare Benefit Plan makes provision to continue Extended Medical and Dental for 12 months during a period of an extended long term disability (LTD) for an employee. The cost of these premiums is to be covered by the local church where the plan member is employed. After that period, the Manulife Follow Me individual plan will be offered to the employee/family. No medical evidence is required for the Follow Me individual plan as long as the employee applies within 60 days of the benefit termination with FGCC. The continuation of group benefits is not dependent on whether the employee is approved for LTD by the insurance company.

TERMINATION OF COVERAGE

Your coverage terminates under this Group if you cease to be eligible due to leave of absence, age limitation or retirement, change of classification, if you terminate your employment or if the Group terminates, etc. Written notification of employee termination is to be provided to the FBP Administrator prior to the last day of employment.

GROUP INSURANCE PLAN

ACTIVE EMPLOYEES AGED 70-74

All active employees at age 70 will be transferred to Class C (ending at age 75 or Retirement). Plan Administrators should alert the National Office minimum one month prior to the employee's 70th birthday to transfer them to Class C.
The premium invoice will continue to be sent to the church.
All coverage is the same as the regular employees except the following: OOC (out of country coverage) would be limited to $50,000 over 5 years and AD&D (Accidental Death & Disbursement) coverage will terminate.

RETIREMENT

Upon retirement of an employee who wishes to remain covered under the plan can be transferred to Class B. Please alert the National Office minimum one month prior to transfer them to this class. Please also send a letter from the church council to confirm their agreement

All coverage is the same as the regular employees except the following

- The Group Life coverage is $10,000.00
- The Accidental Death and Dismemberment is not covered
- Extended Health Care does not cover Out-of-Country medical expenses
- Dental Care does not cover orthodontics
- Long-Term Disability is not covered
- All coverage terminates at age 70

GROUP INSURANCE PLAN

APPENDIX C/ FORM DIRECTORY

New Participant	APPLICATION OF ENROLLMENT FORM (GL2971)
Late Applicant	EVIDENCE OF INSURABILITY (GL0004)
Changes	APPLICATION FOR CHANGE I (GL3187) BENEFICIARY DESIGNATION (GL1435) CONFIRMATION OF DEPENDENT SCHOOL ATTENDANCE (GL4408)
Claims	EXTENDED HEALTH CARE CLAIM (GL3585) DENTAL CLAIM (GL3586) DISABILITY CLAIM (GE10342L GL) DEATH CLAIM (G2007P GL)
Helpful Information	POLICY 0632057 COVERAGE BOOKLET TRAVEL ASSISTANCE BROCHURE (GL1557) TRAVEL ASSISTANCE CARD (GL1255) RESILIENCE SERVICES BROCHURE (GL3676)

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: 632057

Account/Division number: 001

Billing division (if applicable)

Plan member certificate number

Plan sponsor name: Foursquare Gospel Church of Canada

Plan sponsor telephone number: (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: ◯ Male ◯ Female

Province of residence

Language of preference: ◯ 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)

Date of birth of member under other plan (dd/mmm/yyyy)

Relationship to dependant

Is there health coverage? ◯ Yes ◯ No

If *yes*, effective date (dd/mmm/yyyy)

Is there dental coverage? ◯ Yes ◯ No

If *yes*, effective date (dd/mmm/yyyy)

Name of other insurance company

Policy number Certificate number

Dependent child name(s)

Date of birth of member under other plan (dd/mmm/yyyy)

Relationship to dependant

Is there health coverage? ◯ Yes ◯ No

If *yes*, effective date (dd/mmm/yyyy)

Is there dental coverage? ◯ Yes ◯ No

If *yes*, effective date (dd/mmm/yyyy)

Name of other insurance company

Policy number Certificate number

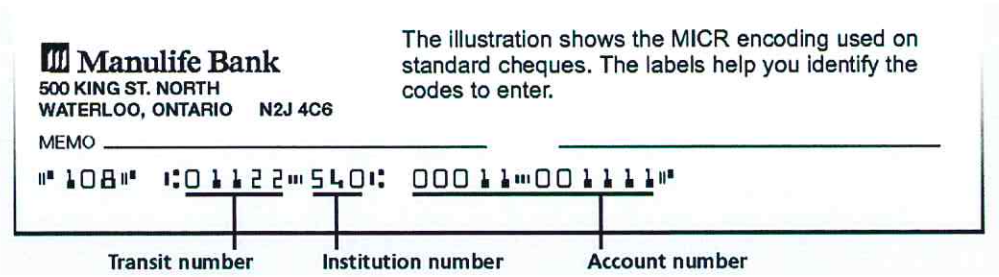
9a Direct deposit

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



The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter.

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: Foursquare Gospel Church of Canada

Plan contract number: 632057

Plan member certificate number

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.

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

Irrevocability

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.

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

Irrevocability

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.

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)

Manulife Financial

Group Benefits
e-Evidence of Insurability - Head Office Plans

INSTRUCTIONS - Please print all answers

1. *Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box to indicate the type of coverage for which you are applying.*
   ◯ *PLAN MEMBER ONLY* ◯ *PLAN MEMBER AND SPOUSE* ◯ *PLAN MEMBER, SPOUSE AND DEPENDANTS* ◯ *SPOUSE AND/OR DEPENDANTS*
2. *Please ensure that ALL SECTIONS are completed.*
   *Section 1 - Plan sponsor information - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR**.*
   Sections 2, 3, 4, 5, 6 and 7 - Plan member/spouse information - To be completed by plan member/spouse and submitted to Manulife Financial.
3. ***If required, retain a photocopy for your files.***

1 Plan sponsor information

Plan contract number(s)	Division number	Plan member certificate number
632057	001	
		Plan sponsor: Foursquare Gospel Church of Canada
Plan administrator name	Phone number: (604) 941-8414	E-mail address

2 Plan member statement

Plan member's name (last, first and middle initial)			Occupation
Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
Plan member's address (number, street, apartment)			
City	Province	Postal code	
Height _____ m _____ cm _____ ft _____ in	Weight ◯ kg ◯ lb	Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No	

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb	Was this a gain or a loss?	Reason

Name of personal physician (last, first and middle initial)		
Address of personal physician (number, street, suite)		Physician's phone number
City	Province	Postal code

3 Spousal statement

Spouse's name (last, first and middle initial)			
Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
Height _____ m _____ cm _____ ft _____ in	Weight ◯ kg ◯ lb	Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No	

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb	Was this a gain or a loss?	Reason

Name of personal physician (last, first and middle initial)		
Address of personal physician (number, street, suite)		Physician's phone number
City	Province	Postal code

4 Dependant information

Please provide the following information for each dependant to be insured.

If you have more than three children, please attach separate sheet (signed and dated) and include all personal information as requested above.

Child's name (last, first and middle initial)

Sex ◯ Male ◯ Female | Date of birth (dd/mmm/yyyy) | Height ________ m ________ cm ________ ft ________ in | Weight ◯ kg ◯ lb

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If "No," please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite) | Physician's phone number

City | Province | Postal code

Child's name (last, first and middle initial)

Sex ◯ Male ◯ Female | Date of birth (dd/mmm/yyyy) | Height ________ m ________ cm ________ ft ________ in | Weight ◯ kg ◯ lb

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If "No," please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite) | Physician's phone number

City | Province | Postal code

Child's name (last, first and middle initial)

Sex ◯ Male ◯ Female | Date of birth (dd/mmm/yyyy) | Height ________ m ________ cm ________ ft ________ in | Weight ◯ kg ◯ lb

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If "No," please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite) | Physician's phone number

City | Province | Postal code

5 Medical questions for proposed insured

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers please attach a separate sheet (signed and dated).

	Plan member	Spouse	Children
1. During the past 12 months have you			
(a) flown as a pilot, student pilot or crew member or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you			
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) been absent from work for medical reasons during the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) currently received any treatment/medications?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(f) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you ever consulted a physician, ever been treated for, or had any known identification of			
(a) chest pain, blood vessel disease, heart disorder, or heart attack or stroke?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) high blood pressure?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinsons)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(g) excessive use of alcohol or drugs?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(h) lung disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(i) bowel, stomach or liver disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(j) cancer?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(k) disorder of the kidney, urine or genital organs?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(l) arthritis, rheumatism or fibromyalgia?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(m) disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(n) immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(o) anemia, or other blood disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Please provide details below, if you have answered "Yes" to *ANY* questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

Question number	Name of person (first & middle initial)	Details or name of condition	Date and duration	Medication/treatment and results (recovery or remaining effects)	Names and addresses of physicians and hospitals

6 Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **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 understand** that any Coverage shall not become effective until approved by Manulife.

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. **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/groupbenefits, or from my Plan Sponsor.

Plan member's name (please print)	
Signature of plan member	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date signed (dd/mmm/yyyy)

Mail to...

Print

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 your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

7 Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1

La version française du document se trouve à l'adresse www.manuvie.ca/assurancecollective.

Manulife Financial

For your future™

Group Benefits – *e*-Application for Change

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

1 General information

We require this information to process your request.

Plan contract number(s)	Plan member certificate number	Plan sponsor
632057		Foursquare Gospel Church of Canada

Plan administrator name	Plan administrator telephone number
	(604) 941-8414 Ext.

Plan member name (last, first, middle initial)

To be completed and signed by plan sponsor.

I certify that the **plan member** listed above 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)

2 Plan member name change

New name (last, first, middle initial)

3 Plan member address

Address (number, street, apt. number)

City	Province	Postal code

4 Addition of benefits

A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.

Addition of Extended Health Care I wish to ADD Extended Health Care for	**Addition of Dental Care** I wish to ADD Dental Care for
◯ Myself ONLY	◯ Myself ONLY
◯ Myself AND 1 dependant	◯ Myself AND 1 dependant
◯ Myself and 2 or more dependants	◯ Myself and 2 or more dependants
◯ My dependants ONLY (I am already covered)	◯ My dependants ONLY (I am already covered)

Dependent Life ◯ I wish to add Dependent Life Insurance

Reason for additions (check one only)

*Please enter the date that the common-law cohabitation began in the "Date commenced" field.

◯ Marriage	◯ Common-law relationship*	◯ Spouse's coverage cancelled
Date of marriage (dd/mmm/yyyy)	Date commenced (dd/mmm/yyyy)	Cancellation date (dd/mmm/yyyy)

◯ Other — Please give details of "Other". If necessary, attach a separate sheet.

Effective date (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. **Manulife Financial will not contact your Plan Administrator to verify that this form has been mailed.**

5 Refusal of benefits

You may refuse Extended Health Care and or Dental Care for yourself and/or your dependant(s) only if covered for similar benefits under spouse's plan.

Refusal of Extended Health Care I do **NOT** want Extended Health Care for	**Refusal of Dental Care** I do **NOT** want Dental Care for
◯ Myself ONLY	◯ Myself ONLY
◯ Myself and my dependant(s)	◯ Myself and my dependant(s)
◯ My dependant(s) ONLY	◯ My dependant(s) ONLY
Date of refusal (dd/mmm/yyyy)	Date of refusal (dd/mmm/yyyy)

If you wish to add coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

6 Termination of dependent coverage

◯ I wish to terminate coverage for a specific dependant(s) (see section 9)

◯ I wish to terminate ALL coverages for ALL dependants

◯ Please change coverage to single

Effective date of termination (dd/mmm/yyyy)

Reason for termination

7 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

8 Co-ordination of benefits

This information is important for the correct adjudication of your claims.

Complete sections 8 and 9 only if you are required to enrol your spouse and children, and you need to change information.

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

Spouse's date of birth (dd/mmm/yyyy)

9 Family information

Complete this section only when you are changing information pertaining to dependants that have previously been enrolled OR when you are adding/deleting a dependant. If more than 4 children, please attach a separate listing.

Change type code A/D/C (see below)	**Effective date of change** (dd/mmm/yyyy)	**Spouse/child name** (last, first, middle initial)	**Date of birth** (dd/mmm/yyyy)	**Sex** (M or F)	Relationship code H/W/S/C (see below)	**Full-time student?** (Yes or No)
		spouse		◯ M ◯ F		N/A
		child		◯ M ◯ F		◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No

Change type codes: **A** = Add, **C** = Change, **D** = Delete **Relationship codes:** **H** = Husband, **W** = Wife, **S** = Common-law spouse, **C** = Child

If a dependant is disabled and over-age, please complete GL0514E, *Application for Over-Age Disabled Dependant Coverage*.
If a dependant is an over-age student, please complete GL4408E, *Request for Termination of Over-age Student Dependant*.

10 Beneficiary designation

Should you wish to change you beneficiary designation, please complete and sign GL1435E, *Beneficiary Designation*.

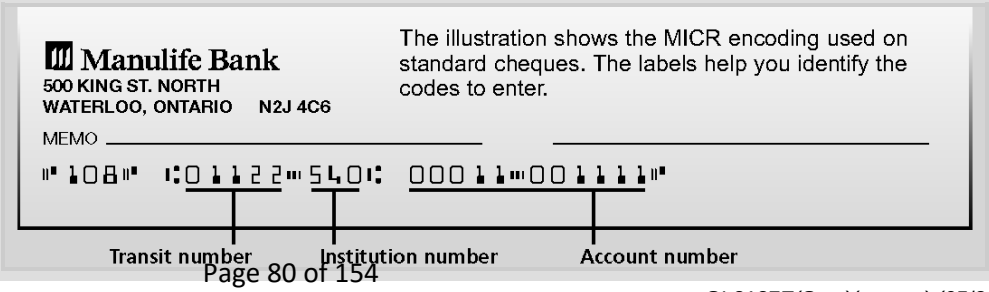
11a Direct deposit

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



11b 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.

Email

12 Plan member signature

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/groupbenefits, or from my Plan Sponsor.

Print

Please sign and date here.

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

13 Mailing instructions

Please send the completed form to:

Plan Member Administration
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1

La version française du document se trouve à l'adresse www.manuvie.ca/assurancecollective

Manulife

Please see reverse for assistance in completing this form.

Send the completed form to: **Plan Member Administration**
Manulife Financial
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8
Fax: 1-877-733-4233

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 and/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, the 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, the 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.

A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original.

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)

Manulife Financial assumes no responsibility for the validity or sufficiency of the content provided by you. The items 'you' and 'yours' refer to the plan member, the term "Plan Sponsor" refers to the entity that offers the group benefits plan, such as an employer.

What is the purpose of a beneficiary?

If you intend for some or all of your death benefit to go to specific individuals, it is important to make sure that you plan ahead and select those beneficiaries. Having an up-to-date beneficiary designation will make this possible by listing your primary and contingent beneficiaries and intended allocations.

Beneficiary: the person, people or entity who will receive any death benefit from the basic or optional coverage you have selected through your group benefits plan that becomes payable upon your death. Basic and optional beneficiaries may differ.

Types of beneficiary – Primary vs. Contingent

Primary: the person, people or entity you choose to receive the death benefits. If you choose more than one beneficiary, you will need to indicate what percentage of the benefit you would like each person to receive. When multiple primary beneficiaries are named, the total of the percentages allocated to each primary beneficiary must add up to 100%.

Contingent: the person, people or entity you designate to receive the death benefits if all of the primary beneficiaries die before you. If you select more than one contingent beneficiary, the benefit will be split evenly between the contingent beneficiaries.

What happens to the death benefit when...

The primary beneficiary dies before you and no contingent beneficiary is named.	The death benefit will be paid to your estate.
The primary beneficiary dies before you, but there is a contingent beneficiary(ies) designated.	The benefit will be paid to the contingent beneficiary(ies).
You assign two primary beneficiaries, and one beneficiary dies before you, and you have not updated your Beneficiary Form information.	The entire death benefit that would have been paid to the deceased beneficiary will be paid to the surviving primary beneficiary.

Irrevocable vs. Revocable

Irrevocable: the beneficiary you choose cannot be changed without the written permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you will not be able to change the beneficiary designation without a completed release form from them.

In Quebec, naming your spouse (must be a civil union) as a beneficiary automatically means that he/she is an irrevocable beneficiary, unless you specify otherwise or divorce.

Revocable: A revocable beneficiary means that the beneficiary you choose can be changed at any time without the permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you can then change that beneficiary designation without asking for that person's permission.

Naming a minor as a beneficiary

If a benefit becomes payable to a minor who is named as a primary or contingent beneficiary, the benefit can only be paid on behalf of the minor to a trustee or guardian for property, otherwise it will be paid into court to be held until the beneficiary has reached the age of majority for your specific province. It is important therefore, if you are choosing a beneficiary who is a minor at the time of the designation to also name a trustee.
If you are a Quebec resident, the parents are considered tutors of their child.
If a minor has been designated as an irrevocable beneficiary, the policy is automatically frozen until the beneficiary has reached the age of majority for your specific province. A parent, guardian or trustee cannot consent to a beneficiary change on behalf of a minor.

Minor: a person named as a beneficiary who is under the age of majority for your specific province.

Trustee: a person appointed by you to hold the minor's proceeds in trust until the minor reaches the age of majority for your specific province.

Tutor: a tutor acts like a trustee.

Manulife Financial

Group Benefits

◯ Request for Over-Age Student Dependant Coverage (Complete sections 1, 2 and 4)

◯ Termination of Over-Age Student Dependant Coverage (Complete sections 1, 3 and 4)

Please complete form and send to: **Plan Member Administration, Manulife Financial, PO Box 2026, HALIFAX NS B3J 2Z1**

1 General information

Plan sponsor name	Plan number(s)	Plan member ID
Foursquare Gospel Church of Canada	632057	

Last name of plan member	First name	Middle initial

Address of plan member	City	Province	Postal code

Last name of dependant	First name	Relationship to plan member	Dependant's date of birth (dd/mmm/yyyy)	Sex ◯ Male ◯ Female

Address of dependant	City	Province	Postal code

2 Full-time student

Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the next school year, the upper limit of the dependant definition age, or until coverage is terminated.

Name of accredited school/college/university	Location of school/college/university

Date school year: Begins (dd/mmm/yyyy)	Ends (dd/mmm/yyyy)

3 Termination of over-age student coverage

This only applies if you have over-age dependant children who are no longer students.

◯ I wish to terminate ALL coverage for DEPENDANT NAME

Effective date of termination (dd/mmm/yyyy)

Reason for termination

4 Plan member signature

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. **I designate** the person(s) named under Beneficiary Designation, as my beneficiary.

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/groupbenefits, or from my Plan Sponsor.

Please sign and date here.

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

Ce document est aussi disponible en français sur demande – GL4408F

Manulife Financial

Group Benefits
Extended Health Care Claim

To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.

1 Plan member information

Plan contract number	Plan member certificate number	Plan sponsor
632057		Foursquare Gospel Church of Canada

Plan member name (first, middle initial, last)	Birthdate (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

Are these expenses eligible for coverage under any type of workers' compensation board? ◯ Yes ◯ No

Are you, your spouse or dependants covered under any other plan for the expenses being claimed?

◯ Yes ◯ No

If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan contract number	Spouse's plan member certificate number

Sign up for direct deposit and electronic claim statements

Receive your claim payments up to 70% faster with direct deposit and enjoy the convenience of seeing your claim statements online.

- Go to www.manulife.ca/groupbenefits and register for the plan member secure site
- Once you've registered, or if you're already registered, log into the secure site and select **Direct deposit for claims** from the menu to the left of the screen
- Enter your banking information

2 Patient information

Complete for all expenses. Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy) (1st Claim only)	Relationship to plan member (1st Claim only)	School and city	If employed, hrs worked per week

3 Prescription drug expenses

- Attach your prescription drug receipts to the back of this form.
- All receipts must contain the drug identification number (D.I.N.) and the name of the prescription drug.
- You are not required to list this information on the form.

4 Practitioner's/ Paramedical expenses

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses please attach an **itemized statement** and/or receipt stating:

- patient name,
- name of practitioner,
- type of practitioner,
- date of service,
- length of visit,
- charge for treatment,
- date last paid by provincial plan (if applicable) and
- licence and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

Please complete next page.

5 Equipment and appliance expenses

For equipment and appliance expenses Manulife Financial requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Indicate the activities requiring the use of this item.

Duration equipment is required. **From** Date (dd/mmm/yyyy) **To** Date (dd/mmm/yyyy)

Has rental equipment been returned? ◯ Yes ◯ No

6 Vision care expenses

To be completed by supplier.

Please enclose an itemized receipt indicating:
- patient's name,
- cost of contact lenses,
- cost of glasses,
- cost of laser surgery,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- date dispensed.

If your contract covers medically necessary contact lenses, please answer the questions below:

Please have the supplier complete and sign below.

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ◯ Yes ◯ No

Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses? ◯ Yes ◯ No

Could visual acuity be improved up to at least the 20/40 level by glasses? ◯ Yes ◯ No

Signature of supplier | Date signed (dd/mmm/yyyy)

7 Claims confirmation

Total amount of ALL receipts submitted $

NOTE - ORIGINAL RECEIPTS must be attached for all expenses

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the 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 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. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Please sign here

Signature of plan member | Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:
- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

8 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:
Manulife Financial Group Benefits
Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1

If you live in Quebec:
Manulife Financial Group Benefits
Health Claims
PO BOX 2580, STATION B
MONTREAL QC H3B 5C6

Manulife Financial

Group Benefits Dental Claim

PART 1 - DENTIST

PATIENT

LAST NAME | GIVEN NAME | UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCT. NO.

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

PHONE NO.

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

☐ DUPLICATE FORM

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF PLAN MEMBER ▶

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF $ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) ▶

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED: $

☐ **CHECK HERE IF TREATMENT PLAN**

WHEN A PROPOSED COURSE OF TREATMENT IS EXPECTED TO COST MORE THAN $500, A TREATMENT PLAN MUST BE FILED WITH MANULIFE FINANCIAL GROUP BENEFITS. YOU WILL BE ADVISED OF THE BENEFITS PAYABLE UNDER THE GROUP PLAN **BEFORE** TREATMENT BEGINS. PRE-TREATMENT X-RAYS ARE REQUIRED FOR SOME PROCEDURES (E.G. CROWNS AND BRIDGES).

PART 2 - PLAN MEMBER INFORMATION

1. PLAN CONTRACT NUMBER 632057

PLAN SPONSOR Foursquare Gospel Church of Canada

NAME OF INSURANCE COMPANY **Manulife Financial**

2. PLAN MEMBER NAME

PLAN MEMBER CERTIFICATE NUMBER

DATE OF BIRTH (DD/MMM/YYYY)

SIGN UP FOR DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENTS

RECEIVE YOUR CLAIM PAYMENTS UP TO 70% FASTER WITH DIRECT DEPOSIT AND ENJOY THE CONVENIENCE OF SEEING YOUR CLAIM STATEMENTS ONLINE.

- GO TO WWW.MANULIFE.CA/GROUPBENEFITS AND REGISTER FOR THE PLAN MEMBER SECURE SITE
- ONCE YOU'VE REGISTERED, OR IF YOU'RE ALREADY REGISTERED, LOG INTO THE SECURE SITE AND SELECT **DIRECT DEPOSIT FOR CLAIMS** FROM THE MENU TO THE LEFT OF THE SCREEN
- ENTER YOUR BANKING INFORMATION

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO PLAN MEMBER

DATE OF BIRTH (DD/MMM/YYYY)

IF CHILD, INDICATE ☐ STUDENT ☐ HANDICAPPED

IF STUDENT, INDICATE SCHOOL

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN. ANY TYPE OF WORKERS' COMPENSATION BOARD OR GOV'T PLAN ☐ NO ☐ YES

PLAN CONTRACT NUMBER

SPOUSE DATE OF BIRTH (DD/MMM/YYYY)

NAME OF INSURANCE COMPANY

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. ☐ NO ☐ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ☐ NO ☐ YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

Please complete both pages of this form.

PART 4 - PLAN MEMBER CONFIRMATION

I CERTIFY THAT I, MY SPOUSE AND/OR MY DEPENDANTS OF MINOR OR MAJOR AGE ("DEPENDANTS"), HAVE RECEIVED ALL GOODS OR SERVICES CLAIMED AND THAT THE INFORMATION PROVIDED FOR THIS CLAIM IS TRUE AND COMPLETE. **I AUTHORIZE** MANULIFE FINANCIAL ("MANULIFE") TO COLLECT, USE, MAINTAIN AND DISCLOSE PERSONAL INFORMATION RELEVANT TO THIS CLAIM ("INFORMATION") FOR THE PURPOSES OF GROUP BENEFITS PLAN ADMINISTRATION, AUDIT AND THE ASSESSMENT, INVESTIGATION AND MANAGEMENT OF THIS CLAIM ("PURPOSES"). **I AM AUTHORIZED** BY MY DEPENDANTS TO DISCLOSE AND RECEIVE THEIR INFORMATION, FOR THE 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 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. **I UNDERSTAND** THAT MANULIFE'S PRIVACY POLICY AND PRIVACY INFORMATION PACKAGE ARE AVAILABLE AT WWW.MANULIFE.CA/GROUPBENEFITS, OR FROM MY PLAN SPONSOR.

SIGNATURE OF PLAN MEMBER **DATE (DD/MMM/YYYY)**

ANY INFORMATION PROVIDED TO OR COLLECTED BY MANULIFE IN ACCORDANCE WITH THIS AUTHORIZATION, WILL BE KEPT IN A GROUP BENEFITS HEALTH FILE. ACCESS TO YOUR INFORMATION WILL BE LIMITED TO:

- MANULIFE EMPLOYEES, REPRESENTATIVES, REINSURERS, AND SERVICE PROVIDERS 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, WHERE APPROPRIATE, TO HAVE ANY INACCURATE INFORMATION CORRECTED.

PART 5 - MAILING INSTRUCTIONS

PLEASE MAIL YOUR COMPLETED CLAIM FORM AND RECEIPTS TO THE APPROPRIATE ADDRESS.

IF YOU LIVE OUTSIDE OF QUEBEC: MANULIFE FINANCIAL GROUP BENEFITS DENTAL CLAIMS
P.O. BOX 1654, WATERLOO ON N2J 4W2

IF YOU LIVE IN QUEBEC: MANULIFE FINANCIAL GROUP BENEFITS DENTAL CLAIMS
P.O. BOX 5000, STATION B, MONTREAL QC H3B 4B5

Print

Manulife

Disability claim form

Initial assessment

Disability claims department

In order to ensure confidentiality of personal information, Manulife will establish a disability claim file in which information concerning all of your disability claims will be kept.

Only employees or authorized agents of Manulife responsible for the management of your claim shall have access to the file.

Tel: 1-877-481-9169 Fax: 1-866-292-9050

MONTREAL
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 400 STN Place-D'Armes
Montreal QC H2Y 3H1

TORONTO
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 4105 STN A
Toronto ON M5W 2P4

CALGARY
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 1315 STN M
Calgary AB T2P 2L2

Instructions for the member

Please complete the "Member statement" section.

Please ensure that the Plan Sponsor completes the "Plan Sponsor statement" section.

Please ensure that your physician completes the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other conditions. As well, please provide your physician with a copy of your completed Member statement so that the physician will have your signed authorization to release information to Manulife.

Please note that any costs incurred in the completion of the "Attending physician statement" are your responsibility.

Please ensure that all of the above-mentioned forms are submitted to Manulife on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.

Please complete the direct deposit authorization at the bottom of this page if you are not already using direct deposit with Manulife. The form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.

Instructions for the Plan Sponsor

Please complete the "Plan Sponsor statement" section.

Instructions for the physician

Please complete the appropriate "Initial Attending Physician's statement", depending on the nature of the primary diagnosis.

DIRECT DEPOSIT AUTHORIZATION*

Plan contract and member numbers

Plan Member Name | Social Insurance Number

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

Name of financial institution

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

Type of account ☐ Savings ☐ Personal chequing ☐ Current | Transit number | Bank account number

I hereby authorize the Manulife to deposit, until further notice, payments due to me from the above policy, into my bank account. I agree that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, I authorize the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Plan Member's signature | Date D D M M Y Y Y Y

* Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

MEMBER STATEMENT

Please note that all questions must be answered in as much detail as possible.

General information

Plan member contract nº | Plan member certificate nº

Title (Mr./Mrs./Ms.) | Surname | Given name(s) | Initial

Address (nº, street) | City | Province

Postal code | Telephone nº | Email

Name of employer (and division if different) | Occupation (just prior to last day worked)

SIN | Date of birth D D M M Y Y Y Y

Language : ☐ English ☐ French | Gender: ☐ M ☐ F | Original date of hire D D M M Y Y Y Y

Tax exempt ☐ Yes ☐ No | If yes, please state reason.

Other current employer ☐ Yes ☐ No | If Yes, please name

Claim information

Was the reason you stopped working due to:

☐ Illness ☐ Injury away from work ☐ Motor vehicle accident (not while working)[1] ☐ Occupational illness or work accident

If you have suffered an injury, please describe how, when, and where the injury occurred.

What was the last day you worked? D D M M Y Y Y Y | Were you performing: ☐ Your regular duties ☐ Modified duties

Was this a full day? ☐ Yes ☐ No | If No, how many hours did you work on your last day?

What was the date you were first unable to work? D D M M Y Y Y Y

When did you first notice these symptoms? D D M M Y Y Y Y

When were you first treated by a physician? D D M M Y Y Y Y

Please describe all of your symptoms, including frequency and severity.

Have you ever had the same or similar illness or injury? ☐ Yes ☐ No

If Yes, please provide the dates and name(s) of physicians who treated you at the time.

Please describe the major duties of your occupation.

MEMBER STATEMENT (CONTINUED)

Please describe why you are unable to perform the duties of your occupation.

Do you have an expected date of return to work? ☐ Yes ☐ No If Yes, please provide the date D D M M Y Y Y Y

Health care professional information

Please list all of the health care professionals you have consulted in the last 12 months, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name Specialty

Complete address Telephone nº Fax nº

Consulted from D D M M Y Y Y Y to D D M M Y Y Y Y

Name Specialty

Complete address Telephone nº Fax nº

Consulted from D D M M Y Y Y Y to D D M M Y Y Y Y

Name Specialty

Complete address Telephone nº Fax nº

Consulted from D D M M Y Y Y Y to D D M M Y Y Y Y

Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable.

Source	Have you applied?		Are you receiving payment?			Monthly amount	Claim no., contact name, telephone no.
	Yes	No	Yes	No	Pending		
Worker's Comp / CSST	☐	☐	☐	☐	☐		
Canada Pension Plan – Disability	☐	☐	☐	☐	☐		
Canada Pension Plan – Retirement	☐	☐	☐	☐	☐		
Québec Pension Plan (QPP) – Disability	☐	☐	☐	☐	☐		
Québec Pension Plan (QPP) – Retirement	☐	☐	☐	☐	☐		
Employment Insurance	☐	☐	☐	☐	☐		
Auto Insurance	☐	☐	☐	☐	☐		
Other Insurer	☐	☐	☐	☐	☐		

Member authorization and declaration

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I agree to refund any monies that I may owe to Manulife in accordance with the provisions of the group benefits plan with Manulife, and I authorize Manulife to deduct such monies from my group benefits. Manulife will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes.

I authorize any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or other benefit programs, the Medical Information Bureau and investigative agency, to release my personal information to Manulife and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize Manulife, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize the use of my Social Insurance Number (SIN) for the purposes of tax reporting. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my plan member certificate number.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original. 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/groupbenefits, or from my Plan Sponsor.

I understand that any personal information provided to or collected by Manulife in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal 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.

Plan Member's Signature

Date D D M M Y Y Y Y

Authorization: e-mail consent

By providing my personal e-mail address, I am authorizing Manulife to use the e-mail address provided as an additional means of communication with me about my file. I acknowledge that correspondence by e-mail may contain personal information including, but not limited to, medical, employment and financial information.

I understand that my personal information is being sent in a manner that is not yet guaranteed as a secured means of communication.

Plan Member's Signature

Date D D M M Y Y Y Y

Manulife

Disability claim form

Initial assessment

Disability claims department

In order to ensure confidentiality of personal information, Manulife will establish a disability claim file in which information concerning all of your disability claims will be kept.

Only employees or authorized agents of Manulife responsible for the management of your claim shall have access to the file.

Tel: 1-877-481-9169 Fax: 1-866-292-9050

MONTREAL
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 400 STN Place-D'Armes
Montreal QC H2Y 3H1

TORONTO
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 4105 STN A
Toronto ON M5W 2P4

CALGARY
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 1315 STN M
Calgary AB T2P 2L2

PLAN SPONSOR STATEMENT

Please note that all questions must be answered in as much detail as possible.

Plan Sponsor information

Name of Plan Sponsor (Employer/Union/Association) | Name of subsidiary or division (if different)

Complete address

Member information

Plan contract number | Division nº | Class nº | Plan member certificate nº

Surname | Given name(s) | Initial

Social insurance number | Permanent employee? ☐ Yes ☐ No

Nature of request for benefits: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Waiver of premiums ☐ Dismemberment

Was the employee actively at work when the absence began / loss occurred? ☐ Yes ☐ No

If Yes, please provide the date on which this member was first covered under this plan contract number: D D M M Y Y Y Y

If No, please comment.

What was the member's date of hire? D D M M Y Y Y Y | last date of work? D D M M Y Y Y Y

If already back at work, what was the start date? ☐ Part-time D D M M Y Y Y Y ☐ Full-time D D M M Y Y Y Y

What was the member's main reason for absence:

☐ Illness ☐ Injury away from work ☐ Motor vehicle accident (not while working) ☐ Occupational illness or work accident

Please indicate the hours of work in a normal week, if shift work, please provide work schedule:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

What was the member's gross weekly salary as of his/her last day of work? | Was the member ☐ Salaried ☐ Hourly

Tax information

Please complete only if benefit is taxable.

TD1 | TP1 | Percentage to be deducted % | TD1 TP1 Member's province of residence for income tax purposes

Did the member receive any income during the disability period? ☐ Yes ☐ No

If Yes, please select one of the following: ☐ Vacation ☐ Maternity leave ☐ Employment insurance ☐ Sick days ☐ Statutory holidays ☐ Other

If Other, please comment.

PLAN SPONSOR STATEMENT (CONTINUED)

Amount $ From D D M M Y Y Y Y to D D M M Y Y Y Y

Has the member submitted a claim to the following government bodies?

☐ WSIB / WCB / CSST ☐ EI ☐ CPP ☐ QPP (RRQ) ☐ Provincial automobile insurance board

Occupational information

What was the member's regular occupation immediately prior to his/her stopping work?

Were the member's duties modified from his/her regular occupation? ☐ Yes ☐ No

Please describe this employee's regular occupation (or attach a copy of the company's job description) as well as any modifications, if any.

The following physical demands analysis of the member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

1. at any one time without a break (approximately) **and**;
2. in total throughout the day (approximately)

Physical demands analysis			1.	2.
Sitting				
Standing				
Driving				
Climbing up and down the stairs				
Lifting with lifting device?	☐ 0 - 10 pounds ☐ 20 - 50 pounds ☐ Yes	☐ 10 - 20 pounds ☐ 50 pounds + ☐ No		
Pushing/Pulling	☐ 0 - 10 pounds ☐ 20 - 50 pounds	☐ 10 - 20 pounds ☐ 50 pounds +		

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.)

Does the participant wear personal protective equipment (i.e. safety glasses/footwear, respiratory protection, ear protection, etc.)? ☐ Yes ☐ No

If Yes, please describe.

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature Title

Telephone Date D D M M Y Y Y Y

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Manulife

Disability claim form

Initial assessment

Disability claims department

In order to ensure confidentiality of personal information, Manulife will establish a disability claim file in which information concerning all of your disability claims will be kept.

Only employees or authorized agents of Manulife responsible for the management of your claim shall have access to the file.

Tel: 1-877-481-9169 Fax: 1-866-292-9050

MONTREAL
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 400 STN Place-D'Armes
Montreal QC H2Y 3H1

TORONTO
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 4105 STN A
Toronto ON M5W 2P4

CALGARY
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 1315 STN M
Calgary AB T2P 2L2

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS)

Patient authorization

Name (last, first, initial) | Plan contract number | Plan member certificate number

Height | Weight | Date of birth D D M M Y Y Y Y

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of the form**."

Patient's signature | Date D D M M Y Y Y Y

Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or date accident occurred? D D M M Y Y Y Y

What was the date of the patient's first visit for his/her current condition? D D M M Y Y Y Y

What was the date of the patient's first visit during the present period of absence from work? D D M M Y Y Y Y

If the patient has a cardiac condition, what is his/her curent functional capacity based on the American Heart Association classifications:

☐ Yes Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Severe Limitation)

What is the patient's blood pressure? Current | Previous | Date D D M M Y Y Y Y

If your patient has a back/spinal condition, have an X-ray, MRI, or any other tests been performed? ☐ Yes ☐ No
If Yes, please attach a copy of the results of the X-rays, MRIs, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? ☐ Yes ☐ No

If Yes, please elaborate.

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS) (CONTINUED)

What are the patient's current limitations **(things that he/she cannot do)**? Please be specific.

What are the patient's current restrictions **(things that he/she should not do)**? Please be specific.

Is your patient competent to manage his/her own financial affairs? ☐ Yes ☐ No

Please indicate the date the patient stopped working based on your recommendation. D D M M Y Y Y Y

If a potential return to work date has been discussed, please provide the date. D D M M Y Y Y Y

Has the patient ever had the same or similar condition? ☐ Yes ☐ No

If Yes, please provide dates and describe.

Is the patient's condition due to injury or sickness arising out of his/her employment? ☐ Yes ☐ No

If Yes, please elaborate.

If the patient was/is pregnant, please indicate the date or expected date of confinement. D D M M Y Y Y Y

Treatment

Frequency of patient visits: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

If Other, please describe.

Please detail the patient's past and present treatment (e.g. date and type of surgery) as well as response to treatment.

Has the patient been hospitalized? ☐ Yes ☐ No

If Yes, please provide the name of the hospital(s) and the dates of confinement.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS) (CONTINUED)

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Name (please print)	Specialty
Complete address	
Telephone nº	Fax nº

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authroized by law. By providing the information you consent to such unedited release of any information contained herein.

Signature

Date D D M M Y Y Y Y

Manulife

Disability claim form

Initial assessment

Disability claims department

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Only employees or authorized agents of Manulife responsible for the management of your claim shall have access to the file.

Tel: 1-877-481-9169 Fax: 1-866-292-9050

MONTREAL
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 400 STN Place-D'Armes
Montreal QC H2Y 3H1

TORONTO
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 4105 STN A
Toronto ON M5W 2P4

CALGARY
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 1315 STN M
Calgary AB T2P 2L2

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS)

Patient authorization

Name (last, first, initial)	Plan contract number	Plan member certificate number

Height	Weight	Date of birth D D M M Y Y Y Y

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of the form**."

Patient's signature	Date D D M M Y Y Y Y

Diagnosis

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I

II

III

IV

V

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? ☐ Yes ☐ No

If Yes, please elaborate.

Please provide a complete list of your patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

When did symptoms first appear? Date D D M M Y Y Y Y

Please describe the patient's initial reason for seeking treatment.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS) (CONTINUED)

Was there a precipitating event? ☐ Yes ☐ No

If Yes, please elaborate.

What was the date of the patient's first visit for his/her current condition? D D M M Y Y Y Y

What was the date of the patient's first visit during the present period of absence from work? D D M M Y Y Y Y

Is your patient's condition caused directly or indirectly by his/her employment? ☐ Yes ☐ No

If Yes, please elaborate.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should** not do)? Please be specific.

Is your patient competent to manage his/her own financial affairs? ☐ Yes ☐ No

Please indicate the date the patient stopped working based on your recommendation. D D M M Y Y Y Y

If a potential return to work date has been discussed, please provide the date. D D M M Y Y Y Y

Treatment

Frequency of patient visits:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

If Other, please describe.

Please detail the patient's past and present treatment (including psychotherapy) response to treatment, and compliance.

Has the patient been hospitalized? ☐ Yes ☐ No

If Yes, please provide the name of the hospital(s) and the dates of confinement.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS) (CONTINUED)

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y

Functional capacities evaluation

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

None: No impairment in this area after basis.
Mild: Suspected impairment of slight importance which does not affect functional ability.
Moderate: Impairment affects but does not preclude ability to function**.**
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
Ability to relate to friends and family members	☐	☐	☐	☐	☐
Ability to attend to personal care (bathing, cooking, etc.)	☐	☐	☐	☐	☐
Ability to carry out household chores	☐	☐	☐	☐	☐
Ability to relate to co-workers and supervisors	☐	☐	☐	☐	☐
Perform work where contact with others will be minimal	☐	☐	☐	☐	☐
Understand, carry out, and remember instructions	☐	☐	☐	☐	☐
Perform tasks involving minimal intellectual effort or repetitive tasks	☐	☐	☐	☐	☐
Perform varied tasks	☐	☐	☐	☐	☐
Ability to follow a regular work schedule	☐	☐	☐	☐	☐
Make independent judgements	☐	☐	☐	☐	☐
Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	☐	☐	☐	☐	☐
Supervise or manage others	☐	☐	☐	☐	☐

Name (please print)	Specialty
Complete address	
Telephone nº	Fax nº

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authroized by law. By providing the information you consent to such unedited release of any information contained herein.

Signature	Date D D M M Y Y Y Y

Manulife

Death claim

Combined statements

Disability claims department
P.O. Box 4002 STN B
Montréal, Québec H3B 4M2
Fax: 1 866 645-4180

PLAN SPONSOR STATEMENT

Plan sponsor name | Plan contract no. | Division no. | Plan member certificate no.

Plan sponsor address (no., street) | City | Province | Postal code

Member surname | Given name(s) | Initial | Class no. | SIN

Main residence address (no., street, apt.) | City | Province | Postal code | Date of birth

1. Occupation | 2. Effective date of the Plan member certificate | Termination date of the Plan member certificate

3. Life volume coverage | Basic | Optional | Dependent | Other

4. Absence during the last twelve months worked ☐ Yes ☐ No From to

5. Nature of request
☐ Death of the Member
☐ Death of a dependent
☐ Death of a retiree

6. Deceased surname and given name(s)

If death of Member, please answer questions 7-10

7. First day worked ☐ Full time ☐ Part time Date

8. Last day worked ☐ Full time ☐ Part time Date

9. Reason for absence ☐ Sick Leave ☐ Retired ☐ Vacation ☐ Lay Off ☐ Other

10. Basic salary on the last day of work ☐ Weekly ☐ Monthly ☐ Annually $

If death of a dependent, please answer question 11

Number of hours worked per week:

11. Was the participant actively at work on the date of the dependent's death? ☐ Yes ☐ No

If no, indicate why:

We hereby certify that the information given above is accurate.

Employer's email address

Nom (en lettres moulées) | Téléphone n° | Authorized employer signee | Date

CLAIMANT STATEMENT (EACH CLAIMANT MUST COMPLETE AND SIGN A CLAIMANT STATEMENT UNLESS HE/SHE IS A MINOR)

Deceased surname | Given name(s) | Date of birth

Date of death | Cause of death | If caused by an accident, specify the circumstances

Claimant (surname and given names) | SIN | Date of birth

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Other | Claimant's email address

I claim in the capacity of ☐ Beneficiary ☐ Executor ☐ Legatee ☐ Heir ☐ Other

I authorize all physicians and other persons who have treated the deceased and all hospitals, institutions and government authorities to provide to Manulife all information in their possession or within their knowledge with respect to the deceased and to honour a photocopy of this authorization.

Address (no, street, apt.) | City | Province | Funeral Home Name

Postal code | Telephone no. | Address | Postal code

Claimant signature | Telephone no. | Email address

Date

In providing this or other claims forms for the convenience of the Claimant, Manulife does not admit any liability or waive any of its rights. Please note that Manulife reserves the right to request official documents and originals in order to proceed with the claim.

ATTENDING PHYSICIAN'S STATEMENT

Please note that this section needs to be completed for claims for which the life insurance amount is more than $300,000.

However, Manulife reserves the right to request that the 'Attending Physician's Statement' be completed although the claim amount is less than $300,000.

This medical Plan member certificate is in conformity with the July 24, 1948, recommendations of the World Health Organization in Geneva. It was adopted by all states in the United States and all provinces in Canada.

In order to ensure that vital statistics are accurate, please refer to the International Listing of Causes of Death.

Deceased surname | Given name(s) | Age at death or Date of birth

Address at time of death (no., street)

Place of death (if deceased in a hospital or institution, please give name) | Date of death

Cause of death (state only one cause under each paragraph a, b and c)*	Interval between onset of illness and death
a) Pre-existent causes. Morbid conditions having eventually caused the above condition. Initial morbid condition to be mentioned last.	a)
b) Caused by or resulting from	b)
c) Caused by or resulting from	c)

*Illness or morbidity directly related to cause of death. This does not relate to the mode of death, for example, heart failure, etc., but to the illness, lesion or complication which caused death.

Other important morbid conditions related to the death, but not related to the illness or the morbid condition, which caused the person to die.

Date on which first treatment was administered for last condition causing death

Date on which last treatment was administered for last condition causing death

Specify whether death was due to an accident, suicide or homicide and give a short description of the circumstances.

Was there an inquest? ☐ Yes ☐ No Was there an autopsy? ☐ Yes ☐ No

If "Yes", who conducted the inquest or performed the autopsy and what were the findings?

To your knowledge, has the deceased smoked cigarettes, small cigars (cigarillos), a pipe or used smoking cessation aids products during the past 12 months? ☐ Yes ☐ No

Have you treated the deceased or has he or she consulted you over the three years prior to the last illness? ☐ Yes ☐ No

To your knowledge, over the last three years, has the deceased been treated by other physicians or in a hospital or other institution? ☐ Yes ☐ No

If you have answered "Yes" to one of these questions, please provide the following information:

Name	Address	Nature of illness or lesion	Date

Physician signature Date

Address City Province Postal code

Manulife Financial

Foursquare Gospel Church of Canada
Group Benefits Program

Table of Contents

Schedule of Benefits

Table of Classes

Class A **All Eligible Employees**

Class B **Retirees**

Class C **Active Employees age 70 and over**

Definitions

Definition of Member:

A person who is directly employed by and compensated for services by the employer on a permanent and fulltime basis. Full time is considered to be a normal work schedule of at least 20 hours per week.

For Retirees: A person who was an employee immediately prior to his retirement

Definition of Dependent:

A Plan Member's legal or common-law spouse or child up to the age noted on the BENEFIT SCHEDULE who is insured under the Provincial Plan.

Definition of Earnings:

The Plan Member's regular rate of pay, including regular bonuses, overtime pay and commissions. Earnings for commissioned Member's will be based on an average of the 2 previous calendar year's T4 earnings.

Benefit Schedule - Employee Life Insurance

Class A

Benefit Amount:	2 x Annual Earnings
Rounded:	Next higher $1,000
Maximum:	$500,000
Guaranteed Issue Limit:	$323,000
Waiver of Premium	
Disability Definition:	24 months, own occupation
Qualifying Period:	119 days
Reduces:	To 50% at age 65
Terminates:	At age 70 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	3 months
Participation Basis:	Mandatory
Contributory:	No

All Classes are subject to the above provisions, with the exception of the following:

Class B

Benefit Amount:	$10,000
Rounded:	N/A
Maximum:	N/A
Waiver of Premium	
Disability Definition:	Lifetime, any occupation
Qualifying Period:	182 days
Eligibility Waiting Period	
Current:	None
New:	None

Class C

Benefit Amount:	$10,000
Rounded:	N/A
Maximum:	N/A
Waiver of Premium	
Disability Definition:	Lifetime, any occupation
Qualifying Period:	182 days
Terminates:	At age 75 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	None

We are grandfathering all current Life Insurance amounts

Benefit Schedule - Accidental Death and Dismemberment

Class A

Benefit Amount:	2 x Annual Earnings
Rounded:	Next higher $1,000
Maximum:	$500,000
Guaranteed Issue Limit:	$323,000
Waiver of Premium	
Disability Definition:	24 months, own occupation
Qualifying Period:	119 days
Reduces:	To 50% at age 65
Terminates:	At age 70 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	3 months
AD&D Plan Type:	6
Participation Basis:	Mandatory
Contributory:	No

Includes:

- Rehabilitation at $10,000 per disability,
- Repatriation at $10,000,
- Family transportation at $1,500 per accident,
- Spousal Occupational Training Expenses at $10,000 per 3 years,
- Dependent Education Benefit at lesser of $5,000 or 5% of employees' AD&D amount over 4 years.
- Day Care Expenses at 5% of employees' AD&D amount to $5,000 per child per year for up to 4 years,
- Home Alteration and Vehicle Modification Expenses at $10,000 over 3 years,
- Seat Belt Benefit at 10% of employees' AD&D amount

We are grandfathering all current Accidental Death and Dismemberment Insurance amounts

Benefit Schedule - Dependent Life

Class A

Spouse:	$10,000
Child:	$5,000
Waiver of Premium	
Disability Definition:	24 months, own occupation
Qualifying Period:	119 days
Survivor Extended:	Not Applicable
Child Definition:	0 days (from live birth) to age 21 (25 if student)
Terminates:	At age 70 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	3 months
Participation Basis:	Mandatory
Contributory:	No

All Classes are subject to the above provisions, with the exception of the following:

Class B

Waiver of Premium	
Disability Definition:	Lifetime, any occupation
Qualifying Period:	182 days
Eligibility Waiting Period	
Current:	None
New:	None

Class C

Waiver of Premium	
Disability Definition:	Lifetime, any occupation
Qualifying Period:	182 days
Terminates:	At age 75 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	None

Benefit Schedule - Extended Health Care

Class A

Deductible:	Single $0 Family $0 Accumulates by Calendar Year
Overall Maximum:	Unlimited Accumulates by Calendar Year
Survivor Extended:	24 months
Child Definition:	0 days to age 21 (25 if student)
Terminates:	At age 70 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	3 months
Participation Basis:	Mandatory
Contributory:	No
Direct Mail:	Yes

Hospital

Room and Board, including Chronic Care

Coinsurance:	100%
Maximum:	Semi Private Applies to: Room and Board Reasonable & Customary Charges 180 days per disability Applies to: Chronic Care

Vision

Vision including Visual Training and Laser Vision Correction

Coinsurance:	100%
Maximum:	$250 for 12 months if under age 18 $250 for 24 months if age 18 or over Change in prescription not required 1 eye exam per 1 calendar year(s) if under age 18 1 eye exam per 2 calendar year(s) if age 18 or over

Drugs and Other

Drugs

ManuScript Drug Plan, Prescription, Generic
Excluding Sexual Dysfunction , Anti-smoking, Fertility and Vaccine drugs
Direct Drugs Including Direct Enrolment, Non-Mandatory Co-ordination of Benefits and Drug Utilization Review

A brand drug for which there is a generic drug will be reimbursed according to cost of the most inexpensive generic drug.

Coinsurance:	70%
Maximum:	Unlimited
Days Supply:	34 days for acute drugs
Days Supply:	100 days for maintenance drugs

Professional Services

Professional Fees & Practitioners	
Coinsurance:	100%
Maximum:	$500 per calendar year per practitioner
Applies to:	Acupuncture Audiologist Dietician Masseur Naturopath Occupational Therapist Osteopath including X-Ray Physiotherapy / Athletic therapist Podiatrist / Chiropodist including X-Ray Psychologist / Social worker Speech Therapy
Maximum:	$550 per calendar year per practitioner
Applies to:	Chiropractor

Medical Services and Supplies

Coinsurance:	100%
Maximum:	$300 per calendar year Applies to: Orthopaedic Shoes $300 per 3 calendar year(s) Applies to: Orthotics $350 per 3 calendar year(s) Applies to: Hearing Aids $300 per lifetime Applies to: Wigs

Out of Country Referral

Coinsurance:	50%
Maximum:	$3,000 per 3 calendar year(s)

Pooled

Private Duty Nursing

Coinsurance:	100%
Maximum:	$10,000 per calendar year

Accidental Dental

Coinsurance: 100%

Out of Country Emergency

Out of Canada Emergency Treatment including ManuAssist with Enhancements and Health Service Navigator

Maximum period: 90 days per trip
Coinsurance: 100%
Maximum: $1,000,000 per lifetime

All Classes are subject to the above provisions, with the exception of the following:

Class B

Eligibility Waiting Period
Current: None
New: None

Out of Country Referral

Not covered

Out of Country Emergency

Not covered

Class C

Eligibility Waiting Period
Current: None
New: None

Terminates: At age 75 or earlier retirement

Benefit Schedule - Dental Care

Class A

Eligible Expenses:	
Level 1 - Basic Services - 6 Month Recall:	
	Diagnostic, Preventive & General Services
	Fillings
	Extractions and Minor Surgery
	Denture Repair, Rebase and Reline
Level 2 - Supplementary Basic Services:	
	Oral Surgery
	Periodontics includes 12 units of scaling
	Endodontics
Level 3 - Major Services:	
	Dentures
Level 4 - Supplementary Major Services:	
	Crowns
	Bridges
Level 5 - Orthodontics:	
	Orthodontics

Includes Direct Enrolment and Non-Mandatory Co-ordination of Benefits

Deductible:	Single $0
	Family $0
	Accumulates by Calendar Year
Coinsurance:	80%
Applies To:	Level 1 - Basic Services - 6 Month Recall
	Level 2 - Supplementary Basic Services
Coinsurance:	50%
Applies To:	Level 3 - Major Services
	Level 4 - Supplementary Major Services
	Level 5 - Orthodontics
Maximum:	$1,500 per calendar year
	Accumulates by Calendar Year
Applies To:	Level 1 - Basic Services - 6 Month Recall
	Level 2 - Supplementary Basic Services
	Level 3 - Major Services
	Level 4 - Supplementary Major Services
Maximum:	Orthodontics $1,500 lifetime
	Orthodontics maximum age 19
	Accumulates by Calendar Year
Applies To:	Level 5 - Orthodontics
Dental Fee Guide:	Current Province of Treatment
Open Space Limitation:	Applies
Survivor Extended:	Not Applicable
Child Definition:	0 days to age 21

	(25 if student)
Terminates:	At age 70 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	3 months
Participation Basis:	Mandatory
Contributory:	No
Direct Mail:	Yes

All Classes are subject to the above provisions, with the exception of the following:

Class B

Eligibility Waiting Period	
Current:	None
New:	None

Class C

Eligibility Waiting Period	
Current:	None
New:	None
Terminates:	At age 75 or earlier retirement

Benefit Schedule - Long Term Disability

Class A

Benefit Amount:	66.7% of the first $3,000 50% of the Excess
Rounded:	Next higher $1
Maximum:	$7,000
Guaranteed Issue Limit:	$6,000
Qualifying Period:	119 days
Maximum Benefit Period	
Total Disability:	Age 65
Rehabilitation:	Applicable
Disability Definition:	24 months, own occupation
Offsets:	Primary CPP/QPP offsets Workers Comp Auto Insurance
Pre-existing Limitation:	Included
All Source Maximum:	85%
Survivor Benefit:	Not Applicable
Tax Status:	Non Taxable
Terminates:	At age 65 or earlier retirement
Eligibility Waiting Period	
Current:	None
New:	3 months
Participation Basis:	Mandatory
Contributory:	Yes

We are grandfathering all current Long Term Disability amounts

Products & Services

Manulife offers a competitive combination of service, product, innovation and convenience.

The Manulife Group Benefits service commitment is based on our customer service capabilities secure Internet services, and claims management.

Group Benefits Customer Service Centre

Our Group Benefits Customer Service Centre uses state-of-the-art, interactive voice response technology (IVR) to provide telephone service for plan administrators and members. We offer the option to obtain information from our IVR or a Customer Service Representative. For plan members or administrators using the Internet, our “Send a note” feature facilitates contact by secure e-mail. We respond to all enquiries on or before the next business day.

Once registered on the Secure Site, a plan member can obtain the following information from the IVR or a Customer Service Representative: coverage information, dependent eligibility information, status of pre-determinations, status of claims cheques, and claims office addresses.

Our Plan Administrator Service Centre can answer detailed questions about your group benefits plan. This includes benefit information beyond the IVR capabilities: plan member administration questions, premium billing and accounting questions. Most questions can be answered immediately, however, if we have to research your question, we will respond within one business day.

The Manulife customer service team has plan specific information at their fingertips to provide that important single point of contact. Our contact management system provides immediate access to a history of past calls, in addition to online reference tools to ensure that you get an answer to your question. Customer Service Representatives respond to questions from callers referred by the IVR, as well as questions sent from our secure Internet sites, ensuring complete integration of service.

Secure Internet Services

The Manulife Internet sites complement our Customer Service Centre. Our public site provides comprehensive information about our products and services, recent legislation, wellness news and much more. Plan members, plan administrators, plan sponsors and plan advisors are able to access detailed plan level information and explore the self-service options in secure areas of our site.

Manulife takes the protection of client confidential information seriously. Activation keys are an additional feature to help protect the confidential information of plan members.

Our online plan member access to claim and benefit information includes:

- Registration for direct deposit for health and dental claim payments
- Personalized “benefits at a glance” coverage summaries
- Detailed claims information
- Complete coverage information - what is covered, for who, and when
- Information on when members are eligible to submit vision claims
- Electronic copies of member booklets
- Online explanation of benefits statements and email reminders when they are ready

The site also offers easy-to-use tools to plan administrators to reduce the paperwork associated with benefits plan management:

- Access to benefit administration forms pre-filled with key group information
- The capability to submit employment and salary changes online
- Ability to view premium statements
- Access to reference information, including plan member booklets, copies of policies, and administration guides
- View coverage information about a plan member and covered dependents

Our Internet offering helps simplify benefit plans and increase the level of convenience for plan members and administrators alike. Manulife continuously enhances online features based on the changing needs of our clients. Rest assured that each change we make considers emerging privacy and confidentiality legislation. Ask your Account Executive for a secure site online demonstration.

Claims Management Expertise

Manulife has a strong track record of claims management. Our reporting capabilities are very robust – Manulife has the ability to measure claims turn around time. However, payment is only part of the process – we focus on accuracy and cost-effectiveness. We understand the importance of delivering service commitments to clients and have established internal targets for accuracy and efficiency.

A key part of this service, our **Explanation of Benefits** (EOB) statement was designed to be user friendly. It provides clear and concise explanations, regardless of the claims decision. We use simple reference codes that identify the reason behind a claim decision and have taken great strides to ensure the explanations are easy to understand. The bottom line is an increased understanding and less administrative time for our clients.

The nature of disabilities has changed in many ways over the past few years. In response to these changes, Manulife has developed a multi-disciplined approach to **disability management**. We will work with clients to build customized disability management programs focused on employee health, productivity, and the financial results they demand. You'll deal with a dedicated team who understands your unique workplace challenges. Our disability management approach affords clients a competitive advantage. Manulife's rigorous, hands-on approach to disability management increases the likelihood of improved financial results on your plan, not to mention more satisfied employees.

Manulife Group Benefits has established aggressive targets for servicing clients from proposal to implementation to day-to-day activities. You can expect our team to be focused on exceeding your service expectations. In fact, a dedicated team within Group Benefits regularly audits a percentage of the claims processed against financial accuracy and non-financial goals. We regularly exceed these goals.

Manulife offers additional reassurance through its **fraud prevention** program. This program is focused on detecting activity that may be associated with plan misuse. We track activity on disability, dental, health care and drug claims. Our system flags unusual activity. Once a certain number of flags are detected, our experienced team investigates the activity behind the scenes. Where necessary, the plan administrator will be contacted with our findings. Manulife is committed to features such as fraud prevention, ensuring the highest standards of claims management and peace of mind for clients.

Finally, Manulife offers a state-of-the-art **pay-direct drug plan, Manu*Script***. Manu*Script* is an electronic drug benefit management program that provides plan members with the convenience of a pay-direct card. It also helps plan members make informed choices about their purchases. With the Manu*Script* program, clients and plan members also benefit from **drug utilization review**. When a plan member presents his or her Manu*Script* benefit card and a valid prescription anywhere in Canada, the pharmacist can review drug history and warn the member of harmful drug interactions, early refills and duplicate drug therapies. In Quebec, employers may choose the option of a deferred payment card.

Manulife is committed to providing the highest standard of service. Clients count on Manulife Group Benefits for its Customer Service Centre, secure Internet services, and claims management expertise – complemented by a comprehensive network of Regional Group Offices focused on your needs.

Resilience® - Manulife's EAP Solution

More and more companies see a direct connection between the health and well being (both physical and emotional) of their employees and the overall success and viability of their business enterprises. Responding to this increased awareness, Manulife Financial has developed a suite of products that allows employers to raise the profile of wellness in the workplace. Launched under the **Health for Life®** product line, **Resilience®** a full service employee and family assistance program, is designed to complement clients' existing group benefits plans. Wellness products can give plan sponsors a "healthy" competitive advantage in their marketplace by creating a culture that leads to improved workplace productivity, increased employee engagement and lower absenteeism. Additional value may also be realized through lower use of some health benefits, such as drug plans or disability benefits.

Manulife delivers these services through an exclusive arrangement with **Human Solutions™**, a leading professional service provider with a national network of professionally accredited psychological counsellors. They are recognized as a preeminent provider of employee and family assistance programs, trauma counselling and e-Health solutions.

About Resilience

Resilience offers a full range of services for both employees and managers.

Employee services

Unlimited access to short-term counselling – Resilience gives your employees and their eligible family members access to professional counselling services to help with a full range of personal issues including, but not limited to:

- Stress
- Alcohol and drug abuse
- Retirement planning
- Sexual harassment
- Conflict resolution
- Weight loss, smoking cessation
- General health issues
- Marital/family/separation/divorce/custody issues
- Personal adjustment problems
- Anger management
- Aging parents/eldercare concerns
- Gambling addiction
- Bereavement
- Psychological disorders

Professional counselling is based on a short-term counselling model. This model provides support and understanding while teaching coping skills and education in self-management techniques. When longer term support is required, the counsellors at Human Solutions refer the employee or family member for ongoing therapy and manage the referral.

This service features:

- direct access, for employees and their eligible family members, to a toll-free number (available 24/7),
- guaranteed confidentiality,
- face-to-face counselling or counselling via telephone or Internet (secure chatroom), depending on employee preference, and
- counselling in many different languages.

Depression Care- is a direct response to the increased incidence of serious mental health issues within employee populations. The depression care response is designed to extend a traditional EAP – which offer short-term counselling, enabling Resilience to treat those members presenting with a diagnosis of clinical depression. Depending upon the location***** a Human Solutions counsellor can deliver personalized sessions using proven counselling techniques to address depression and liaise and consult with an individual's treating physician. The depression care response can deliver up to 20 hours of counselling.

Plan Smart™ Services – Other employee services available through Resilience include:

- **Legal Advisory Service –** provides access to a network of lawyers, through Lawline, a national legal advice service.
- **Financial Advisory Service-** information and/or consultation to assist with decisions relating to money and debt management.
- **Elder and Family Care Service** – provides a needs assessment and follow-up that includes customized information.
- **Nutritional Support-** access to nutritional counselling through certified dieticians. The program offers customized information from four major lifestyle themes including: weight management, heart health, disease prevention and eating for energy.
- **Career Counselling Service-** provides coaching with the plan member to identify and articulate skills, aptitudes, values, personality traits and interests relating to career choice, and also on issues such as problem solving, conflict resolution, change and transition management, and time management.
- **Pre-Retirement Planning Service**- consultation with a career or financial expert to help the plan member prepare for retirement.
- **Smoking Cessation Service**- a personalized support process to help address all facets of smoking, including physical and psychological dependencies.
- **Shift Worker Support**- assist plan members who work shifts in putting together a plan to help provide a healthy and rewarding personal and work life.
- Unlimited access to **online courses** addressing topics including, but not limited to: *Taking Control of your Mood, Taking Control of Job Loss and Transition, Responsible Optimism, Embracing Workplace Change and Resilience: Facing life's challenges with courage and conviction.* etc*.*

Additional Resilience features include:

- **Orientations** that explain the value of taking advantage of an EAP as well as outlining all aspects of **Resilience,** including confidentiality, eligibility, issues covered and how to access the services.

- **Wellness Challenge**** is an online service that helps to promote healthy lifestyles and behaviour change to employees through fun competition. This web-based service assists the employer to establish a set of health habits or behaviours that they would like to encourage and plan members can record their participation. Both individual and group scoring is recorded.

- **Lunch 'n Learn sessions**-** are designed to accommodate one hour lunch periods, are delivered by a professional counsellor, and the topics range from Stress Management, Time Management, and Humour and Laughter, to Communication in Family Life.

**Human Solutions™ counselling is available in major centres across Canada. Contact Human Solutions™ to determine if this service is currently available in your area.*

*** A service fee will apply for groups under 400 lives*

Management services

Resilience offers services for managers and leaders who assist in addressing employee needs and issues and offers solutions to effectively manage workplace situations: These services include:

- online courses,
- trauma response service,
- key person advice line, and
- employee usage reports.

Online courses – The Resilience online learning centre provides unlimited, confidential access to e-courses for managers and leaders. These self-directed, interactive courses cover a wide range of topics including but not limited to: *Managing/Embracing Change, Stress Management* and *Values-Based Leadership*.

Trauma response service – If an unfortunate event occurs at the workplace, the trauma response service provides immediate workplace assistance. This service offers group counselling to help employees and management work through the recovery process.

Traumatic events can include accidents, fire, workplace assault, suicide, death, criminal activity, terrorism, significant organizational change or other stressful events.

Key person advice line – This hotline offers unlimited access to professional coaches who provide direction for managing difficult circumstances with employees. By phone, a member of this team will help assess the situation and create an action plan based on human resource best practices and proven workplace techniques and strategies.

EAP usage reports – These reports provide insight into how employees are making use of the services available through the Resilience program. Due to the confidentiality of this information, reports are only provided when 25 or more employees make use of the services, and no personal identifiers are provided.

Pricing Details

Note that the cost represents a service fee and therefore attracts GST, TVQ and/or HST where applicable.

Resilience is billed separately from the benefits plan by Manulife and cannot be included with Pre-Authorized Debit or included with your Group Insurance premium payment.

Manulife Financial

Emergency Travel Assistance

Member Name

Plan Contract Number

Member Certificate Number

WORLD ACCESS GROUP #

9081

Out-of-province/Out-of-Canada emergency medical assistance

Before you leave Canada, call 1-800-265-9977 for pre-trip assistance.

24-HOUR EMERGENCY CONTACT

CALL BEFORE SEEKING MEDICAL TREATMENT, WHERE POSSIBLE

EMERGENCY TRAVEL ASSISTANCE

1-800-265-9977 CANADA/U.S.

00-1-800-514-3702 MEXICO*

1-888-751-4403 DOMINICAN REPUBLIC

Dialing Prefix + **800-9221-9221** INTERNATIONAL TOLL FREE*

519-741-8450 In other countries, use operator to call collect

*See **www.manulife.ca/groupbenefits/travel** for additional information and for participating countries.

WORLD ACCESS

All Plan conditions apply. Use of this card authorizes the following to collect, use and exchange information for purposes of plan administration, adjudication/ investigation of claims, and patient safety: Manulife, its reinsurers and service providers, the Plan Member, and persons/entities with personal information about the Plan Member, spouse and dependants, including pharmacies and healthcare providers. This card is not transferable. Review our Privacy Policy at www.manulife.ca

GL1255E The Manufacturers Life Insurance Company

Non-transferable
No longer valid when eligibility for benefits has terminated

Manulife

Emergency Travel and After-Hours Assistance

Emergency Travel Assistance

When you're travelling across Canada or to another country, you could face an unexpected medical incident. Emergency Travel Assistance (ETA) from Manulife is designed to help make your business or pleasure travel worry-free.

Emergency Travel Assistance is available through your employer sponsored Group Benefits plan and in association with Manulife's ETA provider, Allianz Global Assistance. These services are explained in this brochure, however, for complete details please refer to your benefits booklet, speak to your plan administrator or contact Manulife's Customer Service Centre directly.

Benefits Of ETA Coverage:

Around-the-clock access:

Help is available 24-hours a day, seven days a week, through the Allianz Global Assistance multilingual call centre. If you need service in a language other than English, just ask. Contact Allianz Global Assistance at the numbers listed on your benefits card or at the end of this brochure.

Information on local medical care:

Allianz Global Assistance will refer you to a local doctor, dentist, pharmacist or other appropriate medical facility.

Monitoring of your medical care:
The professional staff from Allianz Global Assistance will continue to monitor your care and the services you are receiving. They will maintain contact with you, your attending doctor and your Canadian doctor, to help ensure that you are receiving appropriate care.

Limited out-of-pocket expenses:
When contacted, in advance or immediately after receiving assistance, Allianz Global Assistance will manage and pay for your eligible medical expenses, whenever possible.

Should medical assistance be required:

In the event of an unforeseen medical incident, you, your family member or travelling companion must contact Allianz Global Assistance as soon as possible. This is to help ensure that you and your eligible family members receive immediate and appropriate care that is monitored by the professionals at Allianz Global Assistance.

About your coverage

Whether you travel outside your province or country of residence, your coverage is for immediate medical treatment of a sudden, unexpected injury or a new medical condition; or a specific medical problem or chronic condition that was diagnosed but ***medically stable**** prior to departure.

Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

Medically stable means that in the 90 days before departure, the insured person (you or your dependant) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependant) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory for any ongoing or follow-up treatment.

Eligibility requirements

In order to remain eligible for this benefit and services, please be advised of the following:

You must maintain your government health insurance plan (GHIP), for example, your Ontario Health Insurance Plan (OHIP).

You must not travel beyond the maximum number of consecutive out-of-province days as outlined in your benefits booklet.

There may be other limitations such as age restrictions, and dollar limitations. Please refer to your benefits booklet for details or contact the Manulife Customer Service Centre.

Claims payment

To help ensure your claim is managed efficiently, and that you do not incur any unnecessary out-of-pocket expenses, please be aware of the following:

Your policy may require that your claim exceed a minimum dollar amount (e.g. $200) before Allianz Global Assistance can make any payment arrangements with the provider of services. If this is the case, you will need to pay for the expenses yourself, submit them to your provincial health insurance plan, and then submit the outstanding balance to Manulife Group Benefits for consideration. Please refer to your benefits booklet for details and contact Allianz Global Assistance for filing details specific to your plan. Please note that Allianz Global Assistance will still provide assistance services, regardless of the dollar amount of your claim.

Once contacted, Allianz Global Assistance will arrange to pay for all eligible emergency medical expenses, whenever possible. They will also coordinate, where appropriate, payment of the claim on your behalf with your government health insurance plan and Manulife. You will be asked to sign authorization forms allowing Allianz Global Assistance to coordinate this on your behalf.

Allianz Global Assistance will also provide, and guarantee, advance payments to facilities before medical services are provided, when required (whenever possible).

If you do not contact Allianz Global Assistance and pay the provider directly, you must submit the claim to GHIP first for reimbursement. Any outstanding balance may then be submitted to Manulife. Please include a copy of your GHIP statement and a detailed explanation of the circumstances regarding your emergency treatment. Please contact the Manulife Group Benefits Customer Service Centre for information on how to submit your claim.

Please note that if payments made on your behalf are for ineligible services or amounts, Manulife reserves the right to recover any over-payment.

Reimbursement of out-of-pocket expenses is based on reasonable and customary charges as determined by Manulife. Reimbursement is in Canadian funds and is based on the rate of exchange at time of claim.

Claims must be filed within the appropriate time frame as noted in your benefits booklet. For example: within 12 months from the date the claim was incurred.

Medical and hospital benefits

Emergency medical and hospital benefits include (but are not limited to) the following:

- medical referrals to appropriate providers and/or facilities
- in-patient services such as room and board, physician fees, and other medically necessary expenses incurred during your hospital stay
- out-patient services such as physician fees and diagnostic services, etc.
- on-going medical monitoring
- emergency dental treatment*

* Please contact Allianz Global Assistance and/or Manulife for further details and instructions on how to claim.

Transportation and related services

The following benefits may be available in the case of an eligible medical emergency. Please check your benefits booklet for confirmation of your specific coverage.

Medical transportation

If medically necessary, arrangements will be made to transfer you:

- To the nearest and most appropriate medical facility able to provide the care you need.
- To a medical facility in your province of residence.

This may include ground, medical air, and/or commercial air transportation. Round-trip transportation for a qualified medical attendant to accompany and care for you will also be arranged and paid for, if medically required.

Return home of dependant children

If dependant children are left unattended due to the hospitalization of a covered person, transportation arrangements will be made to return them to their normal place of residence. The extra costs over and above any allowance available under prepaid travel arrangements will be paid.

If necessary, round-trip transportation for a qualified escort to accompany the children will be arranged.

Trip interruption/delay coverage:

If your trip is interrupted or return home is delayed, you MAY be entitled to transportation benefits. Please refer to your benefits booklet for details.

Should you choose not to use any offered transportation services, further expenses incurred that directly or indirectly relate to the same illness or injury will not be covered.

Visit by a family member

When a covered individual is travelling alone and requires hospitalization for at least 7 days, the cost of round-trip economy transportation for one family member to visit may be covered. Note that pre-approval from Allianz Global Assistance or Manulife is required.

Return of the deceased traveller

If a covered person dies while travelling, all necessary authorizations will be obtained and arrangements made to transport the body back to the province of residence and/or for cremation at place of death. The costs for preparation and transportation of the body are eligible, up to an allowable dollar maximum. Please check your benefits booklet for complete details. Note that burial expenses, including the cost of a casket or urn, are not covered.

If a covered person dies while travelling alone, one member of the immediate family may be eligible for round-trip economy transportation to identify the body prior to its release.

Meals and accommodations

If you can't travel for medical reasons after you leave the hospital, expenses incurred for meals and/or accommodations after the scheduled date of departure may be covered based on the limitations listed in your benefits booklet.

Vehicle return

If you can't operate your own vehicle or your rented vehicle due to illness, injury or death, arrangements will be made for a commercial agency to return the vehicle to your place of residence, or to the nearest appropriate rental agency. Payment for this service is limited to the amount shown in your benefits booklet.

Non-medical assistance services

Certain non-medical assistance services are also available:

Pre-trip planning and consultation

Up-to-date information is provided for travel advisories, passport, visa, and vaccination and inoculation requirements for your travel destination. Call Allianz Global Assistance before you leave home to verify that travel assistance is available in the country you're visiting. You can also check with Canada's Department of Foreign Affairs and International Trade at www.voyage.gc.ca to determine which countries currently have a travel advisory or by calling 1-800-267-6788 or (613) 944-6788.

Lost or stolen documents and ticket replacement

If your travel documents or tickets are stolen or lost, Allianz Global Assistance will help you contact local authorities to replace them.

Legal referral

When required, Allianz Global Assistance will refer you to a local legal advisor, as well as provide assistance obtaining a cash advance from funds available through personal credit cards, family, or friends.

Telephone interpretation service

Allianz Global Assistance will provide telephone interpretation services, for medical emergencies, in most major languages.

Additional information

Your plan may be subject to specific limits and maximums. Please see your benefits booklet or your plan administrator for more details.

Emergency message service

A telephone/message service will be provided for emergency messages to and from family, friends, or business associates, left by or for you or your covered dependants while travelling. Messages will be held for 15 days.

For complete details, please refer to your benefits booklet.

Limitations:

Neither Allianz Global Assistance nor Manulife are liable for conditions, events or factors that delay, interfere, or prevent the provision of these services.

Neither Allianz Global Assistance nor Manulife are responsible for the availability, quality, or results of any medical treatment received by you or your covered dependants, or the failure to obtain medical treatment or emergency assistance services for any reason.

Manulife and Allianz Global Assistance, in conjunction with the attending physician, reserve the right to return the covered person to his or her province of residence for ongoing treatment. Refusal to comply with the transfer request will end Manulife's liability. The immediate availability of care, treatment or surgery on return to the province of residence is not the responsibility of Manulife or Allianz Global Assistance.

Emergency Travel Assistance is provided to you and your dependants while travelling outside your province of residence for specified periods of time, according to the plan selected by your employer. Please see your benefits booklet for details on the length of time that coverage is provided.

Before you leave:

We recommend that you include these items on your pre-travel checklist:

1. Obtain pre-trip assistance with passport, visa, vaccination and inoculation requirements for your travel destination by calling Allianz Global Assistance.
2. Leave a copy of your travel itinerary at home or with family and friends.
3. Leave a copy of your Passport at home or with family and friends. This can help speed the process in the event your Passport is lost or stolen while you're travelling.
4. If a medical emergency arises and you or your covered dependants can't call for help, please ensure that your travelling companions are aware of all of your necessary personal information so they can call Allianz Global Assistance on your behalf.
5. Obtain and review further details about your Manulife Emergency Travel Assistance coverage as well as the Out-of-Province/Out-of-Canada coverage described in your benefits booklet. By doing so, you'll be familiar with your coverage if an emergency happens while you're away from home.
6. Familiarize yourself with the Allianz Global Assistance contact numbers as noted in this brochure (see end of booklet) or as noted on your benefit card.
7. Keep your Emergency Travel Assistance benefit card with you. It's designed to easily fit into a wallet, money belt or purse and provides important information.

How to access your emergency travel assistance coverage

If an unexpected medical incident occurs while you are travelling:

1. Immediately, or as soon as possible, refer to the Allianz Global Assistance contact numbers noted on the back of your Manulife Financial emergency travel assistance benefit card. You may also refer to the contact numbers noted at the end of this brochure.

2. If you can't call yourself, your family member or travelling companion must contact Allianz Global Assistance. If you do not contact Allianz Global Assistance immediately, you may incur expenses that may not be covered under your Group Benefits plan.

3. Upon contacting Allianz Global Assistance, a Medical Assistance Coordinator will answer the call. If you require service in a language other than English, please ask the coordinator.

4. You will be asked to provide details of the emergency and what type of assistance is required.

5. The Coordinator will also ask for the patient's information:

    a. Allianz Global Assistance plan identification number*

    b. your Manulife Group Benefits policy or plan contract number*

    c. patient's name, plan member's name* and the plan member's certificate number*

    d. provincial health insurance number

    e. location of the emergency (city, country, address, phone number)

    f. the patient's date of departure from home and scheduled return date

    g. the name, address and/or phone number of the patient's family physician in Canada

* This information is included on your benefit card.

6. You will be asked to complete all necessary forms and provide required authorizations.

All details of the emergency situation will be discussed fully with you. If you have any questions, or at any time do not understand something, please do not hesitate to ask.

Emergency contact numbers:

We encourage you to use a land line telephone to make your call as the frequency on mobile phones are not guaranteed outside of Canada.

In **Canada** and the **United States**:
1-800-265-9977

Fax: 1-800-446-7684

Toll Free from Mexico:
00-1-800-514-3702

Note: In Mexico, the prefix numbers (ie. the two zeros) are regionally determined. Example, in some regions the pre-fix requirement may only be one zero. Members are asked to confirm upon arrival to their destination.

Toll Free from Dominican Republic:
1-888-751-4403

Toll Free from other countries that participate in the Universal International Toll Free (UITF):
Dialing Prefix + 800-9221-9221

Note: the UITF number is an 11 digit number with the middle set comprised of 4 digits. This contact number has been validated by the provider.

Note: the country code refers to the country FROM which the member is calling and not the country to which they are calling. Members are asked to confirm upon arrival to their destination.

Note: for participating UITF countries. Visit our website for details: **http://groupbenefits.manulife.com/canada/GB_V2.nsf/public/pm_travel**

In all other countries (for example, those not participating in UITF), use the operator to call collect: 519-741-8450.

Note: some countries do not allow collect calls. You will be required to pay up front. Keep these original receipts and submit to Manulife/Allianz Global Assistance for reimbursement.

Emergency Travel and After-Hours Assistance

After-Hours help at home

ETA isn't just for travel. You can also take advantage of the special After-Hours medical help line from home when you have questions about your health or the health of your dependants.

Not just for emergencies

Your ETA benefit gives you access to practicing, registered nurses with emergency room training and experience – by phone. Whether you're in your own living room or in a hotel overseas, you can phone ETA's Health Advice and Assistance service for answers to your acute health concerns:

- symptoms and treatments of illnesses
- side-effects of drugs or treatments
- drug interactions
- appropriate dosage for over-the-counter drugs
- drug safety during pregnancy

After-hours access

The ETA After-Hours Assistance provides you medical advice from 8 p.m. to 8 a.m. EST when you can't get in touch with your doctor, pharmacist or other health care professionals.

The Allianz Global Assistance representatives will speak to you in English or French, and if service is needed in another language, we have immediate access to professional translators worldwide in any language.

The After-Hours Assistance telephone number is the same number used for other ETA services; just check the back of your ETA wallet card for the numbers to call inside and outside North America.

Follow-up makes the difference

A few hours after you phone, if necessary, the nurse will phone back to check on you and the family member who is ill, and answer any other questions that have come up in the meantime. ETA's After-Hours Assistance service is one of the first in Canada to offer immediate, personalized follow-up.

ETA After-Hours Assistance

When your regular health care professional isn't available (e.g. in the middle of the night.)

1 800-265-9977

Manulife

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Manulife

Resilience® – helpful advice from caring professionals.

When you need a little extra help facing challenges at work, at home and in life.

Resilience

A full-service employee assistance program supporting health at work, at home and in life

Life is full of challenges. Once in a while, a problem may become overwhelming and you may not know how to tackle it alone. An unresolved problem or ongoing stress can sometimes affect your health – emotionally and physically – and eventually, your quality of life. So where can you turn for sound support and solutions?

Help is just a phone call away with **Resilience*** – an employee assistance program available from your employer exclusively through Manulife. If you or one of your eligible family members has a problem or needs advice and someone to talk to, this service offers expert assistance from caring professionals. Through Resilience you can reach a team of experienced counsellors from **Homewood Health™** who will listen to the issue, offer sound advice and help create an action plan to address the issue. For convenience, counselling is available in many different languages.

Resilience is part of your group benefits plan. In most instances, there are no additional out-of-pocket expenses for you or an eligible family member to use this service.

** Resilience is part of Manulife's Health for Life® program.*

What about confidentiality?

Resilience is provided by **Homewood Health,** a national employee assistance provider since 1979. This firm operates independently and its counsellors guarantee the privacy of all individuals who use its services.

Counselling services

Resilience can help with issues including, but not limited to:

- stress
- marital/family/separation/divorce/ custody issues
- alcohol and drug abuse
- personal adjustment problems
- psychological disorders
- anger management
- retirement planning
- aging parents/eldercare concerns
- sexual harassment
- gambling addiction
- conflict resolution
- bereavement
- weight, smoking and general health issues

The counselling is designed to:

- provide support and understanding
- help build coping skills
- teach ways to effectively manage issues and problems

Plan Smart and Career Smart Services

Because we all lead such hectic lifestyles these days, many of us want to be able to manage our own and our family's health and well being in our own way, at times when it works best for us. Homewood Health's Plan Smart and Career Smart Services was designed to allow you to take a proactive approach to managing everyday challenges and life transitions, and get the information and support you need to suit your unique situation. For the most part, all of these services are delivered by phone or online and often include a personalized package of information and useful tools such as software programs that have been selected with your best interests in mind.

Plan Smart and Career Smart Services include:

Childcare and Parenting Caregiver Support Service – Homewood Health's Childcare and Parenting Specialists are able to help parents who may be struggling with any number of parenting issues.

Elder and Family Care Service – Eldercare Specialists work one-on-one with employees providing an immediate needs assessment and follow-up with customized information.

Legal Advisory Service – If you are struggling with a legal issue and don't know where to turn, Homewood Health's Legal Advisory Service can help. It is provided through Lawline, a national legal advice service that gives you easy and convenient access to a network of lawyers.

Financial Advisory Service – A combination of an assessment, information package, and/or consultation with a financial expert will help you make intelligent, informed, and calculated decisions regarding how to best manage your money and debt.

Nutritional Support – Homewood Health's Nutritional Program, designed to help you learn healthy eating habits, improve weight and energy, and resist disease, includes a nutritional assessment, personalized food plans, and one-on-one coaching sessions with a registered dietitian.

Career Counselling Service – Homewood Health's Career Service helps you identify and articulate skills, aptitudes, values, personality traits, and interests as they relate to your career choice, and provide coaching on issues such as problem-solving and conflict resolution, change and transition management, and time management.

Pre-Retirement Planning Service – The Pre-Retirement Planning Service provides the opportunity to speak with a retirement counsellor who will review and provide you with personalized information on planning for your retirement. This may include consulting with a career or financial expert or helpful information on planning to help you enjoy a smooth and stress free transition into retirement.

Smoking Cessation Service – This personalized support process helps you address all facets of smoking, including the physical dependence (i.e. nicotine), as well as the psychological dependence (i.e. smoking habits and the desire to smoke).

Shift Worker Support – If you've been struggling to make working shifts a part of a healthy and rewarding personal and work life, Homewood Health's specialists can help put together a plan that works for you.

Additional Services

Online courses – Topics include, but are not limited to:

- taking control of your mood
- embracing workplace change
- taking control of stress

are available to you at your convenience. The courses are comprehensive, interactive and you can complete them at a pace that meets your schedule and needs. Learn in a new and innovative manner.

12 Weeks to Wellness – This self-directed program offers telephonic coaching with a weight loss and behaviour change consultant. You receive a step-by-step guide to behaviour change, an accompanying CD, and a fitness and weight loss consultation.

Depression care – More and more Canadians are touched by depression, either personally or through someone they know. Resilience can provide assistance for individuals suffering from certain types of depression. Depending on location*, a Homewood Health counsellor can deliver personalized sessions using proven counselling techniques to address the symptoms of depression and will liaise and consult with an individual's treating physician to ensure that all aspects of the treatment program are aligned to deliver the best possible outcomes.

*Homewood Health counselling is available in most centres across Canada. Contact Homewood Health to determine if this service is currently available in your area.

Access is easy

By phone – 1 866 644-0326

To access Resilience by phone, simply call **1 866 644-0326**. (Pour des services en français, composez le **1 888 361-4853**.) This toll-free line is available 24-hours, seven days a week. For calls originating outside of Canada, call **1 604 689-1717** collect for service in English. (Pour des services en français, appelez à frais virés au **1 514 875-0720**.)

TTY service is available for people who are deaf, deafened and hard of hearing. North American callers 1 888 384-1152.

Outside North America, use operator assistance to call collect 1 604 689-1732.

(Pour des services en français, composez le 1 866 433-3305.)

When you call, the customer service representative will:

- Confirm your eligibility by asking you to identify the company you work for.
- Respond to your needs by arranging your first counselling session at a convenient date and time for you or by transferring you directly to a counsellor for immediate assistance.

You can choose to receive counselling in a way that is most convenient and comfortable for you:

- in person
- by phone
- through a secure online service

If you require long-term assistance, Homewood Health will work with you to locate the best support available for you in your community.

Online

Access to all online features is available through the Manulife Plan Member Secure Site: **www.manulife.ca/groupbenefits**

Not registered yet? Follow these easy steps:

Go to **www.manulife.ca**, hover over the sign in button located at the top of the screen, and select **Plan Member** under **Group benefits** from the drop down menu.

Follow the simple onscreen prompts to register your account.

In a few business days, you'll receive a personal site activation key in the mail. When you login to Manulife's Plan Member Secure Site with this key, you'll have access to all online information available to your plan, including Resilience and Health *e*Links®.

Already registered?

If you're registered on Manulife's Plan Member Secure Site, you can access **Resilience** or **Health *e*Links** now – click on Benefits Tools > **Resilience** or **Health *e*Links**.

Health *e*Links

Resilience works in conjunction with Manulife's **Health *e*Links**, an online resource of healthcare-related materials. With Health *e*Links (also part of Manulife's **Health for Life** program), you can take part in an interactive health risk assessment, access a comprehensive library of medical information written by medical experts and even create a personal health improvement program.

The health library includes:

- A searchable drug database with unbiased drug information (find out why the drug is used, how it works, possible side effects and more).
- Up-to-date details about conditions including asthma, depression, high blood cholesterol, high blood pressure and diabetes – and current treatments.
- Answers to questions about diagnostic tests, medical terms, diseases and conditions.

Taking good care of you and your family

Resilience and Health eLinks can help you overcome challenges and take good care of you and your family. For more information, please contact your plan administrator or the person responsible for your benefit plan.

Resilience – for you and your eligible family members

- counselling and other helpful services
- multilingual support (service available in many languages)
- experienced, caring professionals
- easy, convenient access
- complete confidentiality

Resilience can make a big difference in your life and your health.

About Homewood Health

Homewood Health is a recognized leader in the field of Employee Assistance, Workplace Support and Employee Health Management Services. The firm provides EFAP/EAP, Crisis Management, e-Learning, health coaching, leadership development, psychological assessments, and other services in Canada and around the globe.

The Homewood Health mission is to provide behavioural health, productivity and performance solutions that ensure greater employee and organizational effectiveness.

Homewood
Health | Santé

Manulife

Resilience®

CANADA-WIDE 24-HOUR IMMEDIATE RESPONSE

1 866 644-0326
TTY 1 888 384-1152

Homewood Health™

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Counselling for:

- marital & family problems
- stress
- psychological disorders
- alcohol & drug problem
- bereavement
- lifestyle problems
- referral for financial & legal problems
- and more

Homewood Health | Santé

www.manulife.ca/groupbenefits

Manulife

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