

Group Benefits Enrolment or Re-enrolment Application

Please print clearly in dark ink using CAPITAL LETTERS.

Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member.

1	Plan sponsor statement	Plan sponsor name Nishnawbe-Aski Legal	Services Corporation	Plan contract number 110020
		Billing division Account/Divisio	n number F	Plan member's certificate number
		Do you want the waiting period added to the hire	date?	Permanent hire date (dd/mmm/yyyy) _04 SEP 2020
		Re-hire date (dd/mmm/yyyy)	If a re-hire, date previous	ous employment ended (dd/mmm/yyyy)
		Occupation Youth Intervention Workinglass	A Hours worked/w	eek 35.00 Salary \$ 47,500.00 Annually
l c	certify that the plan n	nember listed below is actively at work at their use of at least the set minimum hours per week as st	ual place of employment in o ated in the plan contract over	Canada. Actively at work means the plan member works
		Plan administrator signature Caalet	le 845	Date (dd/mmm/yyyy)
		is strained or meananing requires	your contract.)	rmine if evidence of insurability is required, please refer to
_		If yes, please complete form GL0004E and send	to Manulife for processing.	
2	Plan member information	Plan member's last name Chapman	1	First name ADCI
(To be completed by	Date of birth (dd/mmm/yyyy) 03/04/1997	Gender	Female Province of residence Ontario
	employee	Language English French Do	you have a spouse? (married	d, common law or civil union?) Yes No
3	Plan member address	Address (number, street, apt.) OKimau		
		city Big Trout Lake	Provir	nce Ontario Postal code POVIGO
4	For Quebec re	sidents (age 65 or over) Are you particip	ating in the RAMQ drug plan	? OYes ONo
5	Application for coverage	Some plans allow refusal of certain benefits if the a later date, you may reapply for these benefits a	plan member has coverage t which time satisfactory me	e under their spouse's plan. If you wish to add coverage at dical evidence may be required.
		I am applying for Extended Health Care for	I ar	n applying for Extended Dental Care for
		Myself only	0	Myself only
		Myself and 1 dependant (child or spouse)	0	Myself and 1 dependant (child or spouse)
		Myself and 2 or more dependants (spouse a	nd children)	Myself and 2 or more dependants (spouse and children)
		O None, because my spouse has coverage	0	None, because my spouse has coverage
_		Are you applying for Dependant Life? Yes	Ŋ No Dependant Life m	nay be mandatory. Refer to the policy details.
6	Coordination of benefits	This section is required if you are applying for co Do you or your dependants (spouse and/or child		
		If yes, please provide the following details:	Name of other insurer	
In	sured's last name	First name _		Date of birth (dd/mmm/yyyy)
Ef	fective date of covera	age (dd/mmm/yyyy) Identificatio	n/certificate number	Policy number
PI	ease indicate type of	coverage under other plan:	xtended Health Benefits	Dental Care
le.	acces where the inf	7	Single	Single
	efault value will be ap	nolied	Couple Family	○ Couple ○ Family
			None	○ None

7 Dependant information	in Section	the following section is 5 Application for cover	erage.						
Spouse	Last name	e	First	t name		Date of birt	h (dd/mmm	n/yyyy)	
If there is not enough room to list your	Gender	○ Male ○ Female	e If common law	, please provide th	e effective date of co	ohabitation	(dd/mmm/	['] yyyy)	
dependants, attach details on a separate	**To apply	y for over-age disabled	d dependant coverag	ge, please complet	e form GL0514E.				
sheet.				22 TO 2007		G	ender	Over-age	Over-age
Last name		First name		Date of birt	h (dd/mmm/yyyy)	Male	Female	student	disabled dependant*
						0	0	0	
			H 3. 37/4-2-112-1-1-1			_ 0	0	0	0
						_ 0	0	0	0
						_ 0	0	0	0
8 Direct deposit									
	Transit no	umber 00387							
Complete the following section if you would	Institution	number 010		THE RESIDENCE OF THE PARTY OF T	001122-5400				
like to sign up for direct deposit of your claim		ount number 533	36481						
payments.							Account	t number	
Electronic claim statement		ing your email address							
otatomon.	Work em	ail address och op	swows ucused	d. on . Co. Rers	onal email address (oprilre	vobwor	a gmai	1.com
9 Authorization	and con	sent							
provided by me, and/or portion of this Coverage Lauthorize Manulife to plan administration, aud or organization with Infeplan administrator, insu each other and with Ma on their behalf as if the deductions from my parand administration, if m	e, and future collect, use dit, assessionmation, in rer, investion ulife, its rey were sign y for my Gray SIN is use	re claims thereunder me, maintain and disclosment, investigation, clancluding any medical agative agency, and any einsurers and/or its seating it themselves, and roup Benefits plan, if a ged as my plan member	nay be denied or terr se personal informat aim management, ur and health profession y administrators of o ervice providers, for t d to disclose and recu applicable. <u>I authoriz</u> er certificate number	minated as a resultion relevant to this not relevant to this not remains, facilities or prother benefits prograthe Purposes. Lameive their Informate the use of my So. Lagree a photocome in the process of the second results of the second resul	t of the provision of f s application ("Inform determining plan eli roviders, professiona rams to collect, use, a authorized by my loion, for the Purposes ocial Insurance Num opy or electronic versions.	alse, incor lation") for gibility ("Pu il regulator maintain a Dependant s. <u>I author</u> ber ("SIN") sion of this	nplete, or not the purpose urposes"). I by bodies, a not exchange to conseive my plan of the pure authorizate.	nisleading in es of Group authorize any employer ge this informat to this Autorial a sponsor to rposes of ide ion is valid.	nformation. Benefits any person r, group mation with thorization, make entification
If applicable, <u>I authorize</u> 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. <u>I confirm</u> 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 <u>I understand and agree</u> 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). <u>I also understand and agree</u> 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). <u>I also hereby acknowledge and agree</u> 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.				named by resentative. It to such requested ade by					
understand such corrections. I agree Manulife or by me purs	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			means of sent by the email					
Lunderstand that any	Information	provided to or collect	ted by Manulife in ac	cordance with this	authorization, will b	e kept in a	Group Ber	nefits life, he	ealth or
 persons to wh persons author 	loyees, rep om I have orized by la	resentatives, reinsurer granted access; and w.	rs, and service provi					t d	
I have the right to requi									found in
Manulife's Privacy Poli	cy and Priv	acy Information Packa	age, available at ww	w.manulife.ca/plan	member, or from my	Plan Spo	nsor.	addi dan be	lound III
Plan member signature	Spr	y Chopmon	L			Date signed	d (dd/mmm	/yyyy) <u>031</u>	09/203
40 Mailing instru	otions	Plan Mambar Ac	dministration						

10 Mailing instructions

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



Group Benefits Beneficiary Designation

The Manufacturers Life Insurance Company

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

GL2971E (06/2015) GP/MC

MONTREAL QC H3C 4T8 Fax: 1-877-733-4233

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 n	umber		
•	Trail member morniane.	Nishnawbe-Aski Legal Services Corporation	110020				
		Plan member name (last, first and middle initial)	Province of residence	Date of birth (dd/mmm/yy	yy)		
		Faries,					
2	Primary beneficiary	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member			
ī	List all primary beneficiaries for Basic Life and/or Basic Accidental	Hudson Cybil C. Pl., Name of beneficiary (last, first and middle initial)	04/01/2006 Date of birth (dd/mmm/yyyy)	SiSter Relationship to plan member			
1	Death. Percentages must total 100% to	Hudson Garrett M.D. Name of beneficiary (last, first and middle initial)	15/11/2012 Date of birth (dd/mmm/yyyy)	brother Relationship to plan member	50 % Percentage		
	be valid.	, and a second of the second o			%		
	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.	In Quebec, the designation unless	uebec residents only of your spouse as beneficiary is s otherwise specified. eneficiary, the designation is: able Irrevocable	s irrevocable		
_		Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage		
3	Optional coverage (if applicable)	Tunic of Bottomary (1884)			%		
	Plan contract number	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %		
	List all beneficiaries for Optional Life and/or Optional Accidental	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %		
	Death. 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.	In Quebec, the designation unles	of your spouse as beneficiary of your spouse as beneficiary as otherwise specified. Deneficiary, the designation is:	is irrevocable		
4	Contingent beneficiary	You may wish to designate a contingent beneficiar the primary beneficiary(ies), named above for eith beneficiary will automatically be entitled to the be If you name more than one contingent beneficiary beneficiaries you choose to name. Should there is proceeds will be paid to your estate. Name of contingent beneficiary (last, first and middle initial).	ner coverage, should die be nefit that would have been l y, then the proceeds will be not be any surviving benefic	fore you. In that event, a copayable to the primary beneshit, evenly, amongst the claries at the time of your de	eficiary(ies). contingent eath, the		
		Name of contingent beneficiary (last, first and middle ini	tial) Date of birth (dd/mmm	/yyyy) Relationship to plan r	nember		
5	Trustee appointment	timal M. Musica		as Trustee to receive any ar	mount due to		
	Complete if any beneficiary named is under the age of majority.	I appoint Glizabeth Hudson any beneficiary under the age of majority (not applicable	e in Quebec).	_ as mustee to receive any an	nount due to		
6	Declaration and authorization	<u>I hereby</u> revoke any previous beneficiary design person(s) named above.					
	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	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					
	beneficiary designation in this form is as valid as the original.	information. <u>I acknowledge</u> 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.					
	PRINT	Plan member signature April Chapmoun		Date signed (dd/mm	im/yyyy)		

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Group Benefication Enrolment or Re-enrolment Application

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Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member.

1	Plan sponsor statement	Plan sponsor name Nishnaebe-	Aski Legal Services Corporation Plan contract number 110020
		Billing division A	count/Division number Plan member's certificate number
			ed to the hire date? Yes No Permanent hire date (dd/mmm/yyyy) OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR OR
		Re-hire date (dd/mmm/yyyy)	If a re-hire, date previous employment ended (dd/mmm/yyyy)
		Occupation Gladue Wri	Class Hours worked/week 35.00 Salary \$ 50 K Annually
10	certify that the plan n	nember listed below is actively at w	ork at their usual place of employment in Canada. Actively at work means the plan member works be week as stated in the plan contract over a 52 week period including paid vacation.
a	Hormal work scredule	Plan administrator signature	California Date (dd/mmm/yyyy) 08/07/2019
		Is evidence of insurability required?	your contract.)
_			4E and send to Manulife for processing.
2	Plan member information	Plan member's last name a	rpenter First name Michael
	To be completed by	Date of birth (dd/mmm/yyyy) 19	/04//984 Gender ⊗Male ⊝ Female Province of residence _ ○ W
	To be completed by employee	Language & English Fren	Do you have a spouse? (married, common law or civil union?) Yes No
3	Plan member address	Address (number, street, apt.)	1 Brousseau
		city Jianmins	Province ON Postal code P4N 5Y I
4	For Quebec res	sidents (age 65 or over) Ar	you participating in the RAMQ drug plan?
5	Application for coverage	Corne plans allow relabation certain	benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at see benefits at which time satisfactory medical evidence may be required.
		I am applying for Extended Health	
		Myself only	Myself only
		Myself and 1 dependant (child)	or spouse) Myself and 1 dependant (child or spouse)
		Myself and 2 or more dependa	nts (spouse and children) Myself and 2 or more dependants (spouse and children)
		O None, because my spouse has	coverage
		Are you applying for Dependant Lif	? Yes No Dependant Life may be mandatory. Refer to the policy details.
6	Coordination of benefits		and/or children) have benefit coverage under another benefits plan?
		If yes, please provide the following	letails: Name of other insurer
Ins	sured's last name		First name Date of birth (dd/mmm/yyyy)
Ef	fective date of covera	ge (dd/mmm/yyyy)	Identification/certificate number Policy number
Ple	ease indicate type of	coverage under other plan:	Extended Health Benefits Dental Care
In	cases where the info	rmation is not complete a	○ Single○ Couple○ Couple
	efault value will be ap		Couple Couple Family Family
			O None

						
7 Dependant information	Complete the following section if the p in Section 5 Application for coverage.	lan includes health and/or dental coverage and you	ou have not r	efused ben	efits for you	r dependants
Spouse	Last name	First name	_ Date of bir	h (dd/mmm	ı/yyyy)	
If there is not enough room to list your	Gender OMale OFemale II	f common law, please provide the effective date o	f cohabitation	(dd/mmm/	уууу)	
dependants, attach	**To apply for over-age disabled depe	ndant coverage, please complete form GL0514E.		_	_	
details on a separate sheet.	io apply for over age areamon apply	A CONTRACTOR OF THE PROPERTY O		ender	Over-age	Over-age
Last name	First name	Date of birth (dd/mmm/yyyy)	Male	Female	student	disabled
			0	0	0	dependant**
				_		
				0	0	0
			0	0	0	0
			0	0	0	0
			<u> </u>			
8 Direct deposit	Transit number 04142					
Complete the following	Transit number 81142				<u></u>	В
section if you would like to sign up for direct	Institution numberp 0 /	MEMO"	00011=	0011111		
deposit of your claim	Bank account number 3088	028	ution number		number	
payments.					. Hallinet	
Electronic claim statement	By providing your email address, you	will receive an invitation to register for an online n	Herriber acco	um.	1	0 0100
Statement	Work email address Carpan	tereran legal - on . Ca Personal email addres	s lenn	y.car	Pen tov	rayuur
9 Authorization	and consent				,	
provided by me, and/or portion of this Coverag I authorize Manulife to plan administration, au or organization with Inf plan administrator, insueach other and with Mon their behalf as if the deductions from my pa and administration, if I applicable, Lauthorizaccount ("Account") the me and any other finar I understand and agree Payment(s). I also untherein, and require my Manulife, either by me If applicable, Lauthorizunderstand such communication.	my Dependants, in the future is true ar e, and future claims thereunder may be collect, use, maintain and disclose persidit, assessment, investigation, claim mater, investigation, including any medical and hearer, investigative agency, and any adminulife, its reinsurers and/or its service pay were signing it themselves, and to disty for my Group Benefits plan, if applically SIN is used as my plan member certion of the payments ("Pay Manulife to deposit all payments ("Pay Manulife to deposit of any Payment it I have identified on this form. Lonfinctial institution I choose to name in the fay that upon the deposit of any Payment in the fay that upon the deposit of any Payment in the fay that upon the deposit of any Payment in the fay that upon the deposit of any Payment in the fay that upon the deposit of any Payment in the fay that Manulife is not liable for demands a that Manulife is not liable for demands	that as the applicant, it is my responsibility to enside complete to the best of our knowledge. Lacknowledge denied or terminated as a result of the provision of sonal information relevant to this application ("Information plan alth professionals, facilities or providers, professionistrators of other benefits programs to collect, us providers, for the Purposes. I am authorized by modes and receive their Information, for the Purposele. Lauthorize the use of my Social Insurance Naficate number. Lagree a photocopy or electronic syments") due to me from the above referenced General that this direct bank deposit authorization applied uture; and shall remain valid until revoked in writing into the Account, Manulife is fully discharged at any time and without prior notice, discontinue to future Payment(s). Lalso hereby acknowledge contract or by law, shall not form part of my propered that the Information is being sent in a manner of the which I may incur as a result of interception by a	wiedge and of false, incon offalse, incon offalse, incon offalse, incon offalse, incon eligibility ("P onal regulator ee, maintain a ny Dependan ses. I author wersion of this roup Benefits es to the final ng by me, or from any furt he direct dep and agree erty, and shall reding my Cov that is not gu third party o	agree that more the purposes"). I y bodies, a und exchange to conseive my plan of for the purpose authorization of Payithat any Pabe immedierage, for the reage, for the reage of an email to the purpose of the purpose	this Covera inisleading in isleading in es of Group authorize; ny employe ge this infon t to this Au' sponsor to poses of idi on is valid. olicy"), into t ion herein r horized rep with respect ment(s), as yment(s) ma ately refund the Purposes a a secured ansmission	ge or any fformation. Benefits any person r, group mation with thorization, make entification he bank named by resentative. I to such requested ade by ed to s. L means of sent by
Manulife or by me purs address maintained by Customer Service Cen I understand that any disability file. Access to • Manulife emp • persons to wf • persons auth I have the right to requ	uant to this authorization. Lagree shoul Manulife. Lunderstand that if I do not a ter. Information provided to or collected by my Information will be limited to: loyees, representatives, reinsurers, and nom I have granted access; and orized by law. est access to the personal information i	Id the email address identified on this form change wish to receive emails from Manulife, I can remov Manulife in accordance with this authorization, will service providers in the performance of their jobs in my file, and, where appropriate, to have any ina	e that I am re e my email a I be kept in a s;	sponsible fo ddress onlii Group Ber mation corr	or updating one or by cornection life, he efits life, he ected.	the email ntacting the ealth or
Lacknowledge that m Manulife's Privacy Poli	ore specific details regarding how and v cy and Privacy Information Package, av	why Manulife collects, uses, maintains, and disclos railable at www.manulife.ca/planmember, or from	my Plan Spo	nsor.		
Plan member signatur	, In Ch	<u>T</u>	Date signed	i (dd/mmm	_{'yyy)} 07	108/20F

10 Mailing instructions

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



Group Benefication Enrolment or Re-enrolment Application

Please print clearly in dark ink using CAPITAL LETTERS.

Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member.

1	Plan sponsor statement	Plan sponsor name Nishnaebe-Aski Legal Services Corporation Plan contract number 110020
		Billing division Account/Division number Plan member's certificate number
		Do you want the waiting period added to the hire date? Yes No Permanent hire date (dd/mmm/yyyy) 08/07/20/
		Re-hire date (dd/mmm/yyyy) If a re-hire, date previous employment ended (dd/mmm/yyyy)
		Occupation Gladue Writer Class Hours worked/week 35.00 Salary \$ 50 k Annually
1	certify that the plan r	nember listed below is actively at work at their usual place of employment in Capada. Actively at work mages the plan manufacture of employment in Capada.
а	normal work schedule	e 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
		Is evidence of insurability required? OYes No (in order to determine if evidence of insurability is required, please refer to
_		your contract.) If yes, please complete form GL0004E and send to Manulife for processing.
2	Plan member information	Plan member's last name Carpenter First name Michael
	To be completed by	Date of birth (dd/mmm/yyyy) 19/04/1984 Gender & Male
	employee	Language Æ English French
3	Plan member address	Address (number, street, apt.) 51 Brousseau
		City Timmins Province ON Postal code P4N 5Y1
4	For Quebec res	sidents (age 65 or over) Are you participating in the RAMQ drug plan? Yes No
5	Application for coverage	a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required. I am applying for Extended Health Care for I am applying for Extended Dental Care for
		 Myself only Myself only Myself and 1 dependant (child or spouse) Myself and 1 dependant (child or spouse)
		 Myself and 1 dependant (child or spouse) Myself and 1 dependant (child or spouse) Myself and 2 or more dependants (spouse and children) Myself and 2 or more dependants (spouse and children)
		None, because my spouse has coverage None, because my spouse has coverage None, because my spouse has coverage
		Are you applying for Dependant Life? Yes No Dependant Life may be mandatory. Refer to the policy details.
6	Coordination of benefits	This section is required if you are applying for coverage on your dependants. Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? Yes No
		If yes, please provide the following details: Name of other insurer
Ins	sured's last name	First name Date of birth (dd/mmm/yyyy)
Eff	ective date of coveraç	ge (dd/mmm/yyyy) Identification/certificate number Policy number
Ple	ease indicate type of c	coverage under other plan: Extended Health Benefits Dental Care
In de	cases where the information of the case of	Single Single Couple Family Single Couple Family Single Couple Family
		○ None

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.









Home

My members

Plan documents

Reports

Benefits tools

My profile

Questions

Thank you!

Confirmation #3082150

Name:

April Chapman

Your request was submitted to Manulife for processing on 08 Sep 2020 at 04:13 PM.

Please print and keep a copy of this confirmation.

Finish