THE Great-West Life ASSURANCE COMPANY

Application for membership in a registered pension plan

Return to Great-West Life, Group Retirement Services

1-800-724-3402

SECTION 1 – EMPLOYER/PLAN SPONSOR INFORMATION

Name of employer/plan sponsor	Policy/plan number
Nishnawbe-Aski Legal Services Corporation	68012

SECTION 2 – ISSUER INFORMATION

The group annuity product for the registered pension plan is issued by London Life Insurance Company (the Issuer) 255 Dufferin Avenue, London, ON N6A 4K1. London Life is a subsidiary of Great-West Life. The Great-West Life Assurance Company and key design are trade-marks of Great-West Life, used under licence by London Life for the promotion and marketing of insurance products.

SECTION 3 – APPLICANT INFORMATION (please print)

Last name	Middle initial	First name	Division/subgroup	Identification/employee number
AKIWENZIE	R	GILES		

Social insurance number (SIN)	Date of employment	Date of birth		Language
484 · 212 · 527	2021-02-08	1966-04-17	☑ Male ☐ Female	☑ English ☐ French
I authorize the use of my SIN for tax reporting, identification and record keeping	yyyy mm dd	yyyy mm dd		

Marital status:	Last name of spouse/partner	First name	Email address
☑ Married ☐ Common law ☐ Quebec civil union ☐ Single ☐ Other ____	FARIES	PATRICIA	giles_akiwenzie@hotmail.com Required for online access and to email information about the plan or services connected with it

Address (apt. no., street no., street): 224 LAKESHORE blvd.

City	Province	Postal code
NEYAASHIINIGMING	ONTARIO	N0H 2T0

If the above address is a PO box, general delivery or rural route, also include the civic or street address below

Address (apt. no., street no., street)	City	Province	Postal code

Telephone no.	Alternate telephone no.	Province of employment	Date joined plan
705-262-3554 Ext.	- -	ONTARIO	yyyy mm dd

Registry number (Status Indian) (minimum 10 digits): 1220105701

Is the applicant a connected person? ☐ Yes* ☐ No *Form T1007 must be filed by the employer with Canada Revenue Agency (the plan administrator can help determine whether the applicant is a connected person).

SECTION 4 – BENEFICIARY INFORMATION

Primary beneficiary(ies) on my death

Last Name	First name	Date of birth yyyy mm dd	Relationship to me	% of benefit
FARIES	PATRICIA	1966-02-23	SPOUSE	50
AKIWENZIE,	GILES J.		SON	25
AKIWENZIE,	DANIS L.		DAUGHTER	25
				Total 100%

Unless the law requires otherwise, if one of my primary beneficiaries predeceases me, their share will be paid to the surviving primary beneficiaries in equal shares, or if there is no surviving primary beneficiary(ies), to my contingent beneficiary(ies) named below. If there is no contingent beneficiary(ies), the benefit will be paid to my estate.

Contingent beneficiary(ies) on my death

Last Name	First name	Date of birth yyyy mm dd	Relationship to me	% of benefit
ROOTE,	ANASTASIA	2016 02 01	GRANDAUGHTER	50%
ROOTE,	ANDERS	2019 05 22	GRANDSON	50%
				Total 100%

Application for membership in a registered pension plan (continued)

SECTION 4 – BENEFICIARY INFORMATION (continued)

Contingent beneficiary(ies) on my death (continued)

These designations are for all benefits payable under the plan unless pension legislation or the terms of the plan require payment to my spouse or common-law partner.

All beneficiary designations are revocable **except:**

- where a *Designation of irrevocable beneficiary* form is completed
- where Quebec law applies and I have designated my married or civil union spouse as my beneficiary - the box below applies.

Where Quebec law applies:

- **If I designate my married or civil union spouse as my beneficiary,** they will be irrevocable unless I check the box below. If not, restrictions will apply, unless I obtain the consent of my spouse. For example, I will be prevented from changing my beneficiary, making withdrawals (where permitted) or exercising certain other rights.
  I designate my married or civil union spouse as my revocable beneficiary. ☐
- **Where a minor beneficiary or a person who lacks legal capacity resides in Quebec -** Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks capacity, will be paid to their tutor(s) or curator, unless a valid trust has been established for the benefit of the beneficiary, by will or by separate contract, to receive any such payment and the Issuer has been provided notice of the trust. If a trust has already been established, designate the trust as the beneficiary in this section. **Before designating a trust, legal advice should be sought.**

SECTION 5 – TRUSTEE APPOINTMENT

(to be completed if any of the beneficiaries are minors or otherwise lack legal capacity AND DO NOT RESIDE IN QUEBEC)

If a formal trust does not exist, I hereby appoint:

Full name of **trustee** being appointed (last name, then first)	Trustee for (indicate beneficiary name)	Relationship of trustee to me
ROOTE, CURTIS	ROOTE, ANASTASIA	~~FATHER~~ OF ANA
ROOTE, CURTIS	ROOTE, ANDERS	FATHER OF AND

as trustee to receive, in trust, all benefits payable to any beneficiary designated under the plan who, at the time benefits are paid, is a minor or lacks legal capacity to give a valid discharge according to the laws of the beneficiary's domicile. Payment of benefits to the trustee discharges the Issuer to the extent of the payment. I authorize the trustee in their sole discretion to use the benefits for the education or maintenance of the beneficiary and to exercise any right of the beneficiary under the plan. The trustee may, in addition to the investments authorized for trustees, invest in any product of, or offered by the Issuer or its affiliated financial institutions. The trust for any beneficiary will terminate once that beneficiary is both of age of majority and has legal capacity to give a valid discharge. I direct the trustee to deliver at that time to the beneficiary the assets held in trust for that beneficiary. I or my personal representative may by writing appoint a new trustee to replace the former trustee.

SECTION 6 – PAYROLL DEDUCTION AUTHORIZATION

I authorize my employer to deduct the following from each pay:

- member required contributions under the provisions of the plan; ✓ and,
- if permitted by the plan, additional voluntary contributions of _____. I reserve the right to alter or discontinue this option.

SECTION 7 – INVESTMENT SELECTION

Select investment(s) if the plan sponsor/plan administrator has given members the right to select investments for all or part of the contributions to the plan. If a selection is not made, contributions will be invested in the default investment.

Name of investment and/or code	Percentage	Name of investment and/or code	Percentage
	%		%
	%		%
	%		%

Total allocation must equal 100%

SECTION 8 – CONFIDENTIAL INFORMATION FILE

The Issuer will establish a confidential information file that contains personal information concerning the applicant. By submitting a written request to the Issuer, the applicant may exercise rights of access to, and rectification of, the file. The Issuer will collect, use and disclose the applicant's personal information to: process this application and provide, administer and service the plan applied for (including service quality assessments by or on behalf of the Issuer); advise the applicant of products and services to help the applicant plan for financial security; investigate, if required, and pay benefits under the plan; create and maintain records concerning our relationship as appropriate; and, fulfil such other purposes as are directly related to the preceding. The Issuer may use service providers within or outside Canada. Personal information concerning the applicant will only be available to the applicant, plan sponsor, plan administrator, pension and related government authorities, the Issuer, its affiliates, and any duly authorized employees, agents and representatives of the Issuer or its affiliates, within or outside Canada, for or related to the purpose of the plan, except as otherwise may be required, authorized or allowed by law or legal process, or by the applicant. In all cases, availability is subject to lawful determination by the Issuer. Personal information is collected, used, disclosed, or otherwise processed or handled in accordance with governing law, including applicable privacy legislation, and the applicant's personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. For more information about our privacy practices, please ask for a copy of our Privacy Guidelines brochure.

SECTION 9 – SIGNATURE

I confirm the information on this form and will update it in the future as it changes. I am aware of the reasons the information covered by my authorizations and consents is needed, and the benefits of, and the risks of not, authorizing/consenting. I authorize and consent to the Issuer collecting, using, and disclosing personal information concerning me for the purposes outlined in the Confidential Information File section. This authorization and consent is given in accordance with applicable law and without limiting the authorizations and consents given elsewhere in this application. My authorizations and consents will begin the date this application is signed and end when no longer required. My authorizations and consents may be revoked at any time by either written or electronic notification to the Issuer, subject to legal and contractual considerations. A reproduction of my authorizations and consents will be as valid as the original.

Signature of applicant

February 22, 2021
Date

Manulife

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/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) _____

Re-hire date (dd/mmm/yyyy) _____ If a re-hire, date previous employment ended (dd/mmm/yyyy) _____

Occupation _____ Class _____ Hours worked/week 35.00 Salary $_____ Annually

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 (dd/mmm/yyyy) _____

Is evidence of insurability required? ( ) Yes (●) 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

To be completed by employee

Plan member's last name Akiwenzie First name Giles

Date of birth (dd/mmm/yyyy) 17/Apr/1966 Gender (●) Male ( ) Female Province of residence ON

Language (●) English ( ) French Do you have a spouse? (married, common law or civil union?) (●) Yes ( ) No

3 Plan member address

Address (number, street, apt.) 224 Lakeshore blvd.

City Neyaashiinigming Province ON Postal code _____

4 For Quebec residents (age 65 or over)

Are you participating in the RAMQ drug plan? ( ) Yes ( ) No

5 Application for coverage

Some plans allow refusal of certain benefits if the plan member has coverage under their 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.

I am applying for Extended Health Care for

- ( ) Myself only
- (●) Myself and 1 dependant (child or spouse)
- ( ) Myself and 2 or more dependants (spouse and children)
- ( ) None, because my spouse has coverage

I am applying for Extended Dental Care for

- ( ) Myself only
- (●) Myself and 1 dependant (child or spouse)
- ( ) Myself and 2 or more dependants (spouse and children)
- ( ) 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 _____

Insured's last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

Effective date of coverage (dd/mmm/yyyy) _____ Identification/certificate number _____ Policy number _____

Please indicate type of coverage under other plan:

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

Extended Health Benefits	Dental Care
( ) Single	( ) Single
( ) Couple	( ) Couple
( ) Family	( ) Family
( ) None	( ) None

Continued on the next page

7 Dependant information

Spouse

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

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5 Application for coverage.

Last name Faries First name Patricia Date of birth (dd/mmm/yyyy) 23/Feb/1966

Gender ○ Male ◉ Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy)_____

**To apply for over-age disabled dependant coverage, please complete form GL0514E.

Last name	First name	Date of birth (dd/mmm/yyyy)	Gender Male	Gender Female	Over-age student	Over-age disabled dependant**
			○	○	○	○
			○	○	○	○
			○	○	○	○
			○	○	○	○

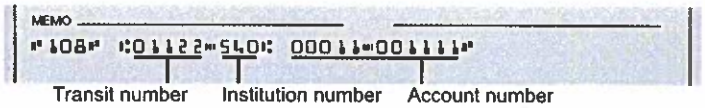
8 Direct deposit

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

Transit number _____

Institution number _____

Bank account number _____



Electronic claim statement

By providing your email address, you will receive an invitation to register for an online member account.

Work email address _____ Personal email address _____

9 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 _____ Date signed (dd/mmm/yyyy) 22/FEB/2021

10 Mailing instructions

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

Manulife

Group Benefits Beneficiary Designation

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

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
Nishnawbe-Aski Legal Services Corporation	110020	
Plan member name (last, first and middle initial)	**Province of residence**	**Date of birth (dd/mmm/yyyy)**
Akiwenzie, Giles		

2 Primary beneficiary

List all primary beneficiaries for Basic Life and/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
Faries, Patricia A.	23/Feb/1966	Spouse	50 %
Akiwenzie, Giles J.	24/May/1989	Son	25 %
Akiwenzie, Danis L.	15/Apr/1995	Daughter	25 %

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, the 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, 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
Roote, Anastasia L.	01/Feb/2016	Granddaughter
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 Curtis Roote, father of Anastasia Roote 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.

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.