ATTENDING PHYSICIAN'S INITIAL STATEMENT
DISABILITY INCOME BENEFITS

This is [illegible] taken from your chart. The patient is respons[illegible] completion.

Johnson, Chantelle M. 50084928
355 Adelaide St Apt 508
Thunder Bay
ON
P7A 7X3
22-May-1982 F
807-345-3934
1954 367 551 XV

Name o[illegible] I.D. #_____

Name o[illegible] Group Plan #_____

I hereby authorize the release of any information requested on this form to The Great-West Life Assurance Company or any of its agents.

Date: Feb 17/09 Signature of Patient: [signature]

1. **History**

Date symptoms first appeared or accident happened. Year 09 Month FEB Day 4.

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

If yes, please specify diagnosis and dates of treatment _____

Please attach a copy of your clinical notes relating to this period of disability.

2. **Diagnosis** (including any complications)

Primary MVA, NECK, MID & LOWER BACK STRAINS.

Secondary _____

Subjective Symptoms: NECK & BACK PAIN

Objective signs (including results of current X-rays, blood pressure, la[illegible] data and any relevant clinical findings):

X RAYS - (N)

3. Current Height N/A Current Weight N/A.

4. In your opinion, when did the patient's condition first prevent him/her from working?

Year 09 Month 2 Day 4

5. **Treatment**

What is the current treatment regimen? (drug dosage, physio, other and progress)

- REST, ICE
- PHYSIOTHERAPY
- MELOXICAM 7.5 BID - FLEXERIL 10mg BID.
- ENDOCET 5 TIDPRN

Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2	09										X							X													

6. If condition is due to pregnancy, what is (or was) the expected date of confinement?

Year _____ Month _____ Day _____

7. Is the condition due to injury or sickness arising out of the patient's employment?
☐ Yes ☑ No
If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

8. Please indicate your patient's current physical abilities:

☑ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light Duties: require frequent handling loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing or pulling may also be required.

☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

List physical restrictions and tolerances: _____

In your opinion, what is the earliest date your patient will be able to return to work?

E&A Year 09 Month 3 Day 2

If the previous job could be modified, when could rehabilitation employment commence?

Year 09 Month 3 Day 2

9. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

_____

_____

10. **Hospitalization** if applicable for this illness or injury

Date of in-patient admission: Year____ Month____ Day____

Date of discharge: Year____ Month____ Day____

Date of out-patient treatment: Year____ Month____ Day____

Name of hospital: _____

11. **Surgery**

Surgical procedure performed: _____

Date of surgery: Year____ Month____ Day____

Name of surgeon: _____

12. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

PATIENT SAYS SHE MAY ATTEMPT RTW 23-2-09

_____

Name of Physician (please print) Dr H.A. NOETZEL

Specialty G.P

Telephone # 807-346-1006 Fax #: 346-6206

Address (number, street, city, province & postal code):

194 N. COURT ST THUNDER BAY ONT P7A-4V7

Physician's signature _____ Date Feb/19/2009

M5454-6/99 04251F

Great-West GROUP

Disability Management

Employee Claim Submission Guide

How to submit a claim for Disability Benefits

This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted within five days of the onset of your disability. Your notice form, and any other correspondence you may wish to provide about your claim, may be submitted to your employer or to the Great-West Life disability management services office assigned to assess your claim. Should you wish to submit your notice form directly to Great-West Life, please contact your employer for the appropriate mailing address.

1. **Notice of Claim**

   The Notice of Claim asks general information about you, your job and the nature of your disability. Please complete all questions on this form and be sure to include your **Group Policy Number.**

2. **Authorization Request**

   We need your permission to obtain information that will help us assess your claim. By signing this authorization request, you give Great-West Life permission to obtain this information from your doctor, your employer, other insurers and hospitals where you received treatment.

3. **Attending Physician's Report**

   Ask your doctor to complete this form. It covers general information on your condition.

WHAT YOU SHOULD KNOW ABOUT THE CLAIM PROCESS

Employer's Statement

Before we can assess your claim, we need a statement from your employer confirming the date your insurance began, your job duties and earnings. We have asked your employer to supply this information directly to us.

Claim Assessment

We will assess your claim as soon as we receive these completed forms from you, your doctor and your employer.

We will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply. If benefits are not approved, Great-West Life will explain the reasons for denial.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor who may charge a fee for preparing it. When Great-West Life requests information directly, a correspondence fee will be offered. You are responsible for paying any fees for information you request.

Medical Coordination/Vocational Rehabilitation

A Medical Coordinator or Vocational Rehabilitation Consultant may contact you during the course of your disability to help you develop a return-to-work plan.

AUTHORIZATION REQUEST

In connection with your claim for benefits, a file will be set up by The Great–West Life Assurance Company. Employees or agents of The Great–West Life Assurance Company will have access to your file, and will request information required to investigate your claim. As part of your claim for benefits, The Great–West Life Assurance Company may provide rehabilitative services, which may include coordinating return to work planning with your employer. The Great–West Life Assurance Company and your employer will need to exchange information related to you in order to facilitate these rehabilitative services.

To assist The Great–West Life Assurance Company with your claim for benefits, you must sign the following authorization before benefits can be considered.

I hereby authorize and direct any physician, dentist, medical or non–medical practitioner, hospital, clinic, pharmacy or other medical or medically–related facility, insurance company, or other organization, institution or person, including my employer, that has any records or information related to me, to give to The Great–West Life Assurance Company or its agent any such information for the purpose of assessing my claim.

I also authorize The Great–West Life Assurance Company to release information to any insurer or benefits administrator, including administrators of government benefits.

I also authorize The Great–West Life Assurance Company to release any information to my employer for the purpose of discussing return to work planning.

Occasionally, an employer, or an agent engaged by an employer, will ask to audit their employees' disability claim files to ensure the efficient assessment of the claims. For audit purposes, I authorize my employer, or an agent of my employer to conduct an audit of my claim, if such an audit is approved by The Great–West Life Assurance Company.

This authorization shall remain valid for the duration of my claim for benefits or until otherwise revoked by me. A reproduction of this authorization shall be as valid as the original.

_____ _____

Print Name Signature

_____

Date

_____

Telephone Number

THE Great-West Life ASSURANCE COMPANY

NOTICE OF CLAIM

Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First_____ Initial_____ Last_____

   Address: Street & Number_____

   P.O. Box_____

   City_____ Province_____ Postal Code_____

2. Telephone Number: Home (_____)_____ Work (_____) _____

   Your Employee Identification Number_____

   Your Identification number must be completed. If unknown, please check with your employer.

3. Social Insurance Number_____

   I authorize the use of my Social Insurance Number only for income tax reporting purposes and as an identification number when required in administering my benefits.

   Employee's Signature_____

4. Date of Birth: Year_____ Month_____ Day_____

   Current Height_____ Current Weight_____

Employer Information

1. Your Employer's Name:_____

   Address: Street & Number_____

   City_____ Province_____ Postal Code_____

   Telephone Number (_____) _____

2. Group Policy Number_____

   Policy number must be completed. If unknown, please check with your employer.

Claim Information

1. What is the nature of your condition?_____
2. If disability is due to an accident, give date accident occurred: Year_____ Month _____ Day _____

   Where and how did it occur?_____

   Was the accident work-related? ☐ Yes ☐ No

   If work-related, have you filed a claim with the Workers' Compensation Board? ☐ Yes ☐ No

   If yes, please provide Workers' Compensation Claim Number and contact phone number.

   _____

3. From what date has your disability continuously prevented you from performing your regular work? Year_____ Month _____ Day _____
4. Have you performed any **other** work since that date? ☐ Yes ☐ No

   If yes, describe_____

5. Are you able to do any other work? ☐ Yes ☐ No

   If yes, describe_____

6. Please provide the name(s) and telephone number(s) of your attending physician(s).

   _____

Financial

1. Have you applied for, or are you receiving the following:

	I have Applied		I am Receiving		
	Yes	No	Yes	No	Amount
Canada Pension Plan/Quebec Pension Plan Benefits	☐	☐	☐	☐	$_____
Workers' Compensation Board Benefits	☐	☐	☐	☐	$_____
Automobile Insurance Benefits	☐	☐	☐	☐	$_____
EI Benefits	☐	☐	☐	☐	$_____
Any other Disability Benefits	☐	☐	☐	☐	$_____
Any other income	☐	☐	☐	☐	$_____
Self Employment Income	☐	☐	☐	☐	$_____

For the duration of your claim for benefits, it is your responsibility to notify Great-West Life of:

- **any work performed, whether or not you have received a wage or remuneration**
- **any employment income paid to you or any other person or party as a result of work performed by you.**

2. Do you have Individual Disability or Life Insurance Coverage with Great-West Life?

☐ Yes ☐ No If so, please provide your policy number:_____

IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF THE INITIAL BENEFIT STATEMENTS.

Date:_____ Signature:_____

DIRECT DEPOSIT AUTHORIZATION

You can have your disability benefit payment cheques automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life.

If you'd like to take advantage of Electronic Funds Transfer, please fill in the information below. If you'd like deposits made to your chequing account, please attach a sample cheque marked "VOID".

Effective_____ please deposit my disability payments to the following account
(date)

☐ Savings Account only, (please consult your bank for proper bank identification no.)
☐ Chequing Account, (please attach sample cheque marked "VOID")

PLEASE PRINT

NAME OF BANK, TRUST CO., CREDIT UNION, ETC.	BANK NO. TRANSIT NO. ACCOUNT NO.
BRANCH ADDRESS	NAME IN WHICH ACCOUNT IS HELD
CITY OR TOWN & PROVINCE POSTAL CODE	

_____ DATE _____ SIGNATURE OF CLAIMANT

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

The Port Arthur Health Centre Inc.

Johnson, Chantelle M. 50084928
355 Adelaide St Apt 508 22-May-1982 F
Thunder Bay 807-345-3934
ON 1954 367 551 XV
FOI P7A 7X3

Attention Patient and Pharmacist: This Prescription cannot be renewed by fax or telephone when expired

℞ DATE - Feb/4/2009 -

Off work Feb 4 → 2nd due to MVA & injuries.

This prescription may be repeated ____ times at intervals of ____ days.

N. P. _____ M.D.

MED.Prescrip.pac.wpd08/03

THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE

(PLEASE PRINT)

TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Policy #: 106790 Division #: _____ Benefit Class: _____ Employee I.D. (if applicable) _____

Company Name: NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

Eligible Date of Employment / Date of Full-Time Employment: Month OCT Day 31 Year 2007

Occupation ASSISTANT TO SPECIAL PROJECTS Earnings: $ 34,500.00 per ☒ Year ☐ Month ☐ Week

Province of Residence: ONT Province of Employment: ONT

EMPLOYEE INFORMATION

Full Name (print): Last: JOHNSON First: CHANTELLE

Birthdate: Month 05 Day 22 Year 82 Gender: ☐ Male ☒ Female

Employee's Mailing Address: 94 PINE ST (Street Address) THUNDER BAY (City) ONT (Province) P7A 5X3 (Postal Code)

DEPENDANT INFORMATION

Do you have dependants? ☐ Yes ☐ No # of dependants COMMON LAW

Do you have a spouse/common-law spouse? ☒ Yes ☐ No

If "Yes" to either of the above questions, **complete the dependant information on the reverse of this page.**

WAIVER OF GROUP HEALTH AND/OR DENTAL COVERAGE

*NOTE: Coverage can only be waived, if you and/or your dependants are covered by a spousal plan.

I understand the group insurance plan offered to me, but I DECLINE to participate in:

Healthcare for: ☐ myself and my dependants ☐ my dependants only Spouse's "Other Insurer" _____

Dentalcare for: ☐ myself and my dependants ☐ my dependants only Spouse's Policy Number _____

If you lose spousal coverage you must apply for coverage within 31 days of loss. If you do not apply within 31 days you will have to provide proof of your insurability to be covered. When you are approved, dental benefits, if applicable, will be limited in the first two years of coverage.

BENEFICIARY DESIGNATION

Beneficiary's Name (First Name, Last Name) MARGARET DONOHUE Relationship to Employee MOTHER

You are responsible to ensure the beneficiary designation is complete.

NOTE: Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable.

I hereby make the designation: ☐ Revocable ☐ Irrevocable

An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.

TRUSTEE CLAUSE: If appointing a minor beneficiary, you may wish to complete this Trustee Clause.

I hereby nominate and appoint the following trustee to receive and disburse any moneys payable under the group policy to my beneficiary(ies) during minority, and any payments made to this trustee will release THE GREAT-WEST LIFE ASSURANCE COMPANY of any further liability.

Trustee's Name (First Name, Last Name) _____ Relationship to Employee _____

AUTHORIZATIONS AND DECLARATIONS

Protecting Your Personal Information At Great-West, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West or the offices of an organization authorized by Great-West. We limit access to information in your file to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefit plan.

I apply for coverage under the group benefit plan issued by The Great-West Life Assurance Company ("Great-West").

I authorize:

- my employer or plan sponsor to deduct from my pay and remit to Great-West any contributions required under the group benefit plan;
- Great-West to use my Social Insurance Number to administer my coverage and benefits under the group benefit plan;
- Great-West, any healthcare provider, my plan administrator, other insurance companies, or benefit service providers working with Great-West to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefit plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

I confirm that a photocopy or electronic copy of this authorization is as valid as the original.

[*For Quebec Applicants:* I request that all communication and documents be in English. Je demande à ce que toute communication me soit remise en anglais.]

I certify that the information given is true, correct and complete to the best of my knowledge.

_____ Employee's signature

NOV 7, 2007 Date

SEE REVERSE

Policy #: 106790

Employee Name: CHANTELLE JOHNSON

DEPENDANT INFORMATION

SPOUSE INFORMATION:

First Name: BROOK Last Name: MAINVILLE Gender: ☒ Male ☐ Female

Date of Birth: Month June Day 30 Year 79

Indicate your spouse's coverage with their employer:

Health:	☐ Single	☐ Family	☐ Waived	☒ None
Dental:	☐ Single	☐ Family	☐ Waived	☒ None
Vision:	☐ Single	☐ Family	☐ Waived	☒ None

OTHER DEPENDANT INFORMATION:

First Name: ______ Last Name: ______ Gender: ☐ Male ☐ Female

Disabled? ☐ Yes ☐ No Birthdate: Month ______ Day ______ Year ______ Student? ☐ Yes ☐ No

First Name: ______ Last Name: ______ Gender: ☐ Male ☐ Female

Disabled? ☐ Yes ☐ No Birthdate: Month ______ Day ______ Year ______ Student? ☐ Yes ☐ No

First Name: ______ Last Name: ______ Gender: ☐ Male ☐ Female

Disabled? ☐ Yes ☐ No Birthdate: Month ______ Day ______ Year ______ Student? ☐ Yes ☐ No

First Name: ______ Last Name: ______ Gender: ☐ Male ☐ Female

Disabled? ☐ Yes ☐ No Birthdate: Month ______ Day ______ Year ______ Student? ☐ Yes ☐ No

THE Great-West Life ASSURANCE COMPANY

GROUPNET GROUP COVERAGE CHANGE FORM

For GWL Head Office Use Only
GWL Certificate Number

Please print clearly and complete both sides of this form, in INK. Sections 1 & 2 are to be completed by the plan administrator and sections 3 through 11 are to be completed by the plan member, for applicable changes. The plan administrator should keep a copy of the completed form for their records and send the **original** to The Great-West Life Assurance Company.

1. General Enrollment Information

Plan number: 106790 Division number: 001

Plan sponsor: Nishnawbe-Aski Legal Services Corporation.

Plan member name: JOHNSON CHANTELLE Plan member ID: 101.
(last name / first name / middle initial)

2. Reinstatement

This information will be used to re-enroll the plan member in the group benefits plan.

Plan member returned to work on: Month _____ Day _____ Year _____

Reason for reinstatement (E.g., return from leave of absence, return from lay-off) _____

3. Refusal of Benefits

Cross outs and/or corrections in this section must be initialled.

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **I decline** to participate in:

Healthcare for ○ myself and my dependants ○ my dependants only

Dentalcare for ○ myself and my dependants ○ my dependants only

Spousal insurer's name: _____ Plan number: _____

Effective date of change: Month _____ Day _____ Year _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependants may be required to provide proof of insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. Addition of Group Health and/or Dental Benefits

You may apply to be enrolled for group coverage if your spouse has lost group benefits coverage through his/her employer.

Effective date of loss of coverage through spousal plan: Month _____ Day _____ Year _____

Indicate the benefit(s) no longer covered under the spousal plan:

○ Healthcare ○ Dentalcare

5. Dependant Information Change

This section must be completed if you are adding or deleting a dependant, or updating dependant information.
If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Effective date of change: Month _____ Day _____ Year _____

To: ○ Single coverage ○ Family coverage

Reason: ○ Birth of child ○ Divorce ○ Marriage ○ Cohabitation Date of marriage/cohabitation: Month _____ Day _____ Year _____

○ Other (please specify) _____

Spouse Information

Add ☒ Change ○ Delete ○

MAINVILLE (last name) Brook (first name) (middle initial)

Date of birth (month/day/year): 1979/30/06

Gender: Male ☒ Female ○

What group benefits coverage does your spouse have through his/her employer?

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
○	☒	○	○	○	☒	○	○	○	☒	○	○

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Dependant Information

Add	Change	Delete	last name	first name	middle initial	Date of birth month/day/year	Gender Male	Gender Female	Full time student Yes	Disabled dependant Yes
☒	○	○	MAINVILLE	MIGWAN		05/05/00	○	☒	☒	○
○	○	○					○	○	○	○
○	○	○					○	○	○	○
○	○	○					○	○	○	○

CONTINUE ON REVERSE SIDE

M6109(GN)-4/07

To be completed by the plan administrator

Plan number: _____ Plan member name: _____ Plan member ID: _____

6. Plan Member Name Change

From: _____ To: _____
last name first name middle initial last name first name middle initial

7. Beneficiary Designation Change

This section must be completed to change the designated beneficiary or beneficiaries for your life benefits.

The original of this form will be required for a life claim.

Crossed out beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Beneficiary's name(s)	Percent allocated	Relationship to plan member
last name first name middle initial		
last name first name middle initial		
last name first name middle initial		

To be divided as follows: ○ As per the percentages indicated above, or
○ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable", below.

I hereby make the above beneficiary designation:

○ **Revocable,** I may change this beneficiary designation at any time

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

8. Current Beneficiary Name Change

Complete if a current beneficiary has had a legal change of name.

From: _____ To: _____
last name first name middle initial last name first name middle initial

Relationship to plan member: _____

9. Opting Out of all Group Benefits

You may opt out of your group benefits plan, if your coverage is non-compulsory.

Opting out of all group benefits - for non-compulsory plans only.

○ I understand the group benefits plan offered to me, but **I decline** to participate.

If at any time in the future you wish to join the group benefits plan, you and your dependants will have to provide proof of insurability acceptable to Great-West Life to be covered. If approved, dental benefits, if applicable, may be limited.

Effective date: Month _____ Day _____ Year _____

Please see your plan administrator for details.

10. Privacy

This section explains Great-West Life's commitment to privacy.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life),** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to determine your eligibility for coverage, and to administer the plan, including investigating and assessing claims, and creating and maintaining records concerning our relationship.

11. Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

Authorizations and Declarations

I hereby apply for coverage under the group benefits plan issued by Great-West Life.

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: _____ **Date:** _____

Plan administrator signature: _____ Date: _____ Feb/05/13

BROOK MAINVILLE 101
JUNE 30, 1977

TRISTAN EDWARD MIKINAAK MAINVILLE
JUNE 15, 2010

update GWh for Chantelle

System does not allow

Manulife

A

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 Plan contract number

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) 31/OCT/07

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

Occupation Restorative Justice Assistant Class A Hours worked/week 35 Salary $ 40,849 Frequency 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 (dd/mmm/yyyy) 07/DEC/2017.

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 JOHNSON First name CHANTELLE

Date of birth (dd/mmm/yyyy) 22/05/82 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.) 881 HUDSON AVE

City THUNDER BAY Province ON Postal code P7A 6J5

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	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 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

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 GREAT WEST LIFE

Insured's last name MANVILLE First name BROOK Date of birth (dd/mmm/yyyy) 30/06/77

Effective date of coverage (dd/mmm/yyyy) Identification/certificate number [redacted]0000000219 Policy number 156804

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

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.

Spouse

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

Last name MANVILLE First name Brook Date of birth (dd/mmm/yyyy) 30/06/77

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**
MANVILLE	TRISTAN	15/06/2010	☒	○	○	○
MANVILLE	MUIRGWAN	05/03/2008	○	☒	○	○
			○	○	○	○
			○	○	○	○

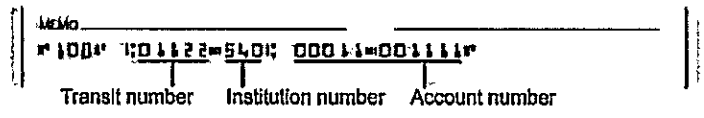
8 Direct deposit

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

Transit number 03872

Institution number 003

Bank account number 9057644



Electronic claim statement

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

Work email address SJohnson@manlegal.on.ca 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) 06/12/17

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 [illegible]		
Plan member name (last, first and middle initial)	**Province of residence**	**Date of birth (dd/mmm/yyyy)**
CHANTELLE M. JOHNSON	ON	22/05/82

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
BROOK MAINVILLE	30/06/77	HUSBAND	33.33 %
TRISTAN E. MAINVILLE	15/06/2010	SON	33.34 %
MIIGWAN MAINVILLE	05/03/2000	DAUGHTER	33.33 %

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
			%
			%
			%

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

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 BROOK MAINVILLE 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)
[signature]	06/12/17

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.