



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 Nishanashi Leach Service Corp 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) 02/Jul/2011

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

Occupation Youth Intervention Class A Hours worked/week 35 Salary \$ 40 531.98 Frequency Annual

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 [Signature] Date (dd/mmm/yyyy) 20/Sep/2018

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

Plan member's last name McKay First name William John

Date of birth (dd/mmm/yyyy) 14/01/57 Gender Male Female Province of residence Ontario

To be completed by employee Language English French Do you have a spouse? (married, common law or civil union?) Yes No

3 Plan member address

Address (number, street, apt.) Kasabonika Lake - Box # 133

City Samias above Province Ontario Postal code P0V-1Y0

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 those 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

WM

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:

Extended Health Benefits

Dental Care

- Single
- Couple
- Family
- None

- Single
- Couple
- Family
- None

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

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 McKay First name Joyce Date of birth (dd/mmm/yyyy) 26/04/53 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.

Table with 6 columns: Last name, First name, Date of birth (dd/mmm/yyyy), Gender (Male/Female), Over-age student, Over-age disabled dependant. Rows include Shewaybick Cole Ethan and McKay Jamie Austin.

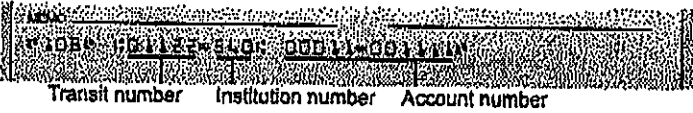
8 Direct deposit

Transit number 24037

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

Institution number 001

Bank account number 3994-490



Electronic claim statement

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

Work email address kmckay@manulife.com 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 William John McKay Date signed (dd/mmm/yyyy) 23/01/18

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



Please see reverse for assistance in completing this form.

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

Group Benefits Beneficiary Designation

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

1 Plan member information

Plan sponsor name	Plan contract number	Plan member certificate number
Plan member name (last, first and middle initial) <i>McKay William John</i>	Province of residence <i>ONTARIO</i>	Date of birth (dd/mm/yyyy) <i>14/01/1957</i>

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) <i>McKay Jane A</i>	Date of birth (dd/mm/yyyy) <i>26/04/53</i>	Relationship to plan member <i>WIFE</i>	Percentage %
Name of beneficiary (last, first and middle initial)	Date of birth (dd/mm/yyyy)	Relationship to plan member	Percentage %
Name of beneficiary (last, first and middle initial)	Date of birth (dd/mm/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

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

5 Trustee appointment

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

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

6 Declaration and authorization

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

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

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 <i>William John McKay</i>	Date signed (dd/mm/yyyy) <i>23/01/18</i>
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