

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 A A							
1	Plan sponsor statement	Plan sponsor name NShyawbe Ask hegal Services 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 O No Permanent hire date (dd/mmm/yyyy) 26/11/2018							
		Re-hire date (dd/mmm/yyyy) If a re-hire, date previous employment ended (dd/mmm/yyyy)							
		Occupation Training Conductor Class A . Hours worked/week 35 Salary \$ 34,580 Frequency							
l c	certify that the plan r	nember listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works at least the set minimum hours per yeek as stated in the plan contract over a 52 week period including paid vacation.							
		Plan administrator signature lack the Suts Date (dd/mmm/yyyy) 61/05/2019							
		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 Quequish First name Stallone							
	To be completed by	Date of birth (dd/mmm/yyyy) 05-05-1987 Gender Male Female Province of residence ON							
	employee	Language							
3	Plan member address	Address (number, street, apt.) 42-Seventh Avenue-B							
		City Sioux Lookout Province ON Postal code P8T 1H5							
4	For Quebec re	sidents (age 65 or over) Are you participating in the RAMQ drug plan? Yes No							
5	Application for								
J	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 2 or		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							
_		Are you applying for Dependant Life? Yes No Dependant Life may be mandatory. Refer to the policy details.							
6	Coordination	This section is required if you are applying for coverage on your dependants.							
	of benefits	Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan?							
		If yes, please provide the following details: Name of other insurer Manulife							
Ins	sured's last name Qu	pequish First name Danielle Date of birth (dd/mmm/yyyy) 10-12-1986							
Ef	fective date of covers	ge (dd/mmm/yyyy) 01-07-2018 Identification/certificate number 100000134 Policy number 0067089							
Pl	ease indicate type of	coverage under other plan: Extended Health Benefits Dental Care							
In	cases where the info	Single Single Couple							
d	efault value will be ap	plied. Family Family							
		○ None							

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	Last name Queq	uish	First nar	me Danielle	_ Date of birth	dd/mmr	1/уууу)1(0-12-1986	
f there is not enough oom to list your	Gender O Male	Female	If common law, ple	ase provide the effective date	of cohabitation	(dd/mmm/	/yyyy)		
dependants, attach details on a separate sheet.	**To apply for over	**To apply for over-age disabled dependant coverage, please complete form GL0514E.							
Last name		First name		Date of birth (dd/mmm/yyyy) Male	ender Female	Over-age student	Over-age disabled dependant	
Binguis		Blayne		05-04-2004	<u> </u>	0	0	0	
Binguis		Javier		01-06-2006	<u> </u>	0	0	0	
Quequish		Caiden		01-10-2011	•	0	0	0	
Quequish		Josiah		18-09-2013	•	0	0	0	
8 Direct deposit	Transit number 01	1242							
Complete the following				MEMO					
section if you would like to sign up for direct	Institution number			" 108" "O1122"540	: 000 1 1 m O	01111		2 3-24	
deposit of your claim payments.	Bank account num	ber 503821		Transit number Insti	itution number	Account	number		
di - ti - stredirez-succe							Humber		
Electronic claim	By providing your	email address, y	ou will receive an invi	tation to register for an online	member accou	nt.			
statement	Mark amail address	squequish	0 1 1				O "		
	VVOIK eman addres	ss oquequioni	@nanlegal.on.ca	Personal email addre	ss stallonequ	uequish(@gmail.co	om	
hereby apply for cove certain aspects of such true and complete to th	and consent rage ("Coverage") u Coverage may exte	inder the Group lend to my spouse	Benefits plan issued t e and eligible dependa nd that as the applica	Personal email addre o my plan sponsor by Manulife ants (collectively, "Dependents nt, it is my responsibility to ens	e Financial ("Ma "). <u>I certify</u> that	anulife"). L	understand	I that s form is statement	
Lhereby apply for coverein aspects of such true and complete to the provided by me, and/or portion of this Coverage authorize Manulife to be an administration, autor organization with Infolan administrator, insue ach other and with Materia their behalf as if the deductions from my and administration, if applicable, Lauthorize account ("Account") the ame and any other finant understand and agreement(s). I also understand in the Account of applicable, Lauthorize and any other finant understand and agreement (s). I also understand such correction and the provided in the Account of applicable, Lauthorize and such corrections understand such corrections and the provided in the Account of applicable, Lauthorize and such corrections understand such corrections understand such corrections. Lagreement of the provided in the pro	and consent rage ("Coverage") u Coverage may exte e best of my knowle my Dependants, in e, and future claims i collect, use, maintai dit, assessment, inve- ormation, including a rer, investigative age inulife, its reinsurers by were signing it ther y for my Group Bene y SIN is used as my the Manulife to deposi to I have identified or cial institution I choo the that upon the deperstand and agree personal written end int, to which I am not or by representatives the Manulife to corres spondence may core that Manulife is not uant to this authoriza	ander the Group lend to my spouse dge. <u>I understal</u> the future is true thereunder may in and disclose pestigation, claim any medical and ency, and any action and/or its service mselves, and to efits plan, if applied plan member control in this form. <u>I control</u> to any Payments of any Payments of any Payments of any Payments of any estate. Spond with me this of my estate. Spond with me this in Information. I liable for damagation. <u>I agree</u> should be true and the spond and the spond and the spond and the spond with me the spond with the	Benefits plan issued to and eligible dependand that as the applicate and complete to the bedenied or terminal personal information remanagement, underwhealth professionals, dministrators of other lose providers, for the Pedisclose and receive it is able. Lauthorize the ertificate number. Lag "Payments") due to mistirm that this direct be future; and shall rement(s) into the Accountag, at any time and wing to future Payment(s) by contract or by law, rough the email addres; and that the Informanages which I may incurould the email addres	o my plan sponsor by Manulife ants (collectively, "Dependants nt, it is my responsibility to ensibest of our knowledge. <u>Lackmy</u> led as a result of the provision elevant to this application ("Information and facilities or providers, profession benefits programs to collect, us urposes. <u>Lam authorized</u> by their Information, for the Purpose use of my Social Insurance Name a photocopy or electronic of the effort of the above referenced Gank deposit authorization applimation. Manulife is fully discharged thout prior notice, discontinue to the effort of the social not form part of my properties in the series of the series in a manner as a result of interception by as identified on this form regartion is being sent in a manner as identified on this form changing sidentified sidenti	e Financial ("Ma"). I certify that sure that any fu by whedge and a formation") for the eligibility ("Puronal regulatory se, maintain anny Dependants ses. I authoriz lumber ("SIN") in version of this a Group Benefits less to the financing by me, or many further the direct depode and agree the erty, and shall be reding my Cover that is not guar a third party of a se that I am ress	anulife"). Lit the informather verba or expected that plete, or me purpose poses"). Lit bodies, and exchange it to consert or the purpose my plan for the purposital institution of the purpositation of the purpositati	understance nation in this all or written this Covera insileading in the set of Group authorize any employer get this information to this Authorize sponsor to poses of ideon is valid. Alicy"), into the ion herein nonized represent(s), as ryment(s) materially materially refunded as ecured in ansmission or updating to	I that I	
Lhereby apply for coverentain aspects of such true and complete to the provided by me, and/or portion of this Coverage authorize Manulife to olan administration, autor organization with Infolan administrator, insue each other and with Material their behalf as if the deductions from my particular administration, if applicable, Lauthorize account ("Account") the me and any other finant understand and agreement(s). Lalso understand such correction, and require my Manulife into the Account Manulife, either by me for applicable, Lauthorize and such corrections munication. Lagreement and such corrections munication and such corrections and suc	and consent arage ("Coverage") u Coverage may exte e best of my knowle my Dependants, in e, and future claims collect, use, maintai dit, assessment, inve- promation, including a rer, investigative age inulife, its reinsurers by were signing it there by SIN is used as my by SIN is used as my by Manulife to deposi at I have identified or cial institution I choo- be that upon the dep- personal written end int, to which I am not or by representatives by Manulife to corres spondence may con a that Manulife is not uant to this authorize Manulife. I understa er. Information provided my Information will lo obyees, representativ om I have granted a rized by law.	ander the Group lend to my spouse dge. <u>I understal</u> the future is true thereunder may in and disclose pestigation, claim any medical and ency, and any actions and for its service medical and ency, and any action in the service medical and ency, and any action in the service medical plan, if applied plan member control in this form. <u>I control</u> is of any Payments of any estate. It is of my estate. It is of any estate. It is of my estate.	Benefits plan issued to and eligible dependand that as the applicate and complete to the be denied or terminal personal information management, underwhealth professionals, dministrators of other local providers, for the periodisclose and receive the providers, for the periodisclose and receive the disclose and receive the disclose and receive the entificate number. Lag "Payments") due to minima that this direct be future; and shall rement(s) into the Accountary, at any time and wing to future Payment(s) by contract or by law, arough the email addres; and that the Informates which I may incurrently the email address of wish to receive emails and service providers and service providers.	o my plan sponsor by Manulife ants (collectively, "Dependants nt, it is my responsibility to ensibest of our knowledge. Lackmy led as a result of the provision elevant to this application ("Information and facilities or providers, profession benefits programs to collect, us urposes. Lam authorized by their Information, for the Purpose use of my Social Insurance Name a photocopy or electronic of the effort the above referenced of ank deposit authorization applimain valid until revoked in writing. Manulife is fully discharged thout prior notice, discontinue as a last hereby acknowledges shall not form part of my properties in seeing sent in a manner as a result of interception by a sidentified on this form regarding in the performance of their jobs ance with this authorization, with the performance of their jobs in the performance of their jobs.	e Financial ("Ma"). I certify that sure that any furwhelde and a few formation") for the eligibility ("Puronal regulatory se, maintain any Dependants sees. I authorize the eligibility ("Sin") oversion of this a feroup Benefits less to the financing by me, or many further the direct depote and agree the erty, and shall be the erty of a feron that is not guar at hird party of a fer that I am respectively and shall be that I am respectively and shall be that I am respectively and shall be seen that I am respectively and shall	anulife"). Lit the informather verbagee that plete, or me purposes"). Libodies, and exchange to conser to the purpose model institution of the purpose insti	understance nation in this all or written this Covera insiste adding in the set of Group authorize any employer to this Authorize to this Authorized reproduced in the set of Group authorized reproduced in the set of the	I that a form is statement ge or any formation. Benefits any person, group nation with horization, make entification he bank amed by esentative. to such equested de by ed to	
Lhereby apply for cover certain aspects of such true and complete to the provided by me, and/or portion of this Coverage authorize Manulife to olan administration, author organization with Infolan administration, insue each other and with Materian their behalf as if the deductions from my parand administration, if applicable, Lauthorize account ("Account") the me and any other finant understand and agreement (s). Lalso understand such correction, and require my Manulife into the Accound Manulife, either by me and any other by me pursaddress maintained by Customer Service Cent understand that any disability file. Access to Manulife emplessons author have the right to request acknowledge that moderation and control acknowledge that moderation acknowledge tha	and consent rage ("Coverage") u Coverage may exte e best of my knowle my Dependants, in e, and future claims collect, use, maintai dit, assessment, inve- formation, including a rer, investigative age inulife, its reinsurers by were signing it there by SIN is used as my see Manulife to deposi to I have identified or cial institution I choos that upon the dependent of the monor by representatives the Manulife to corres the Manulife to corres the Manulife to corres the Manulife is not to this authorize that Manulife. I understa ter. Information provided my Information will it obyees, representative one I have granted a rized by law. 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Lam authorized by their Information, for the Purpose use of my Social Insurance Name a photocopy or electronic of the formation applimain valid until revoked in writing, Manulife is fully discharged thou prior notice, discontinue is). Laiso hereby acknowledges shall not form part of my propersistion is being sent in a manner as a result of interception by a significant with this form changials from Manulife, I can removance with this authorization, will ance with this authorization, will apply the sent of the provision of the	e Financial ("Ma"). I certify that sure that any fure that any fure that any fure that sure that any fure that is eligibility ("Pure onal regulatory se, maintain any Dependants ses. I authorization of this action of this action of this action of the sure that is not guard that is n	anulife"). Lit the information retrieved that plete, or me purpose poses"). Lit bodies, and exchange to conser exchange to conser exchange to conser exchange to conser exchange of the purposial institution duly authorization policy ("Pocial institution duly authorization policy ("Pocial institution duly authorization duly authorization duly authorization policy ("Pocial institution duly authorization duly aut	understand nation in this all or written this Covera- nisleading in ses of Group authorize a ry employer ge this inforr at to this Aut sponsor to poses of ide on is valid. dicy"), into th ion herein n horized repr with respect nent(s), as r yment(s) ma ately refunde the Purposes a secured r ansmission or updating t the or by conf efits life, hea	I that Is form is Is statement Is statement Is or any Is formation. Is Benefits Inny person Is group Ination with Individual in the Interest of the Is of th	

10 Mailing instructions

Plan Member Administration

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

Manulife Group Benefits Enrolment

SECTION 7: Dependant Information (Continued)

Last Name:

First Name:

Date Of Birth: (dd/mm/yyyy)

Gender:

Quequish

Weston

14-04-2019

Male



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					
		Plan member name (last, first and middle initial)	Province of residence ON	Date of birth (dd/mmm/yy 05-05-1987	уу)				
2	Primary beneficiary	Name of beneficiary (last, first and middle initial) Danielle Quequish	Date of birth (dd/mmrn/yyyy) 10-12-1986	Relationship to plan member Married	Percentage 100 %				
	List all primary beneficiaries for Basic Life and/or Basic Accidental Death.	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %				
	Percentages must total 100% to be valid.	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %				
	Irrevocability	Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation.	For Quebec residents only In Quebec, the designation of your spouse as beneficiary is irrev unless otherwise specified. If spouse is beneficiary, the designation is: Revocable Irrevocable		s irrevocable				
3	Optional coverage (if applicable)	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %				
	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 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.	In Quebec, the designation unless	For Quebec residents only lation of your spouse as beneficiary is irrev unless otherwise specified. se is beneficiary, the designation is: Revocable 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 beneficiary will automatically be entitled to the beneficiaries you choose to name. Should there no proceeds will be paid to your estate. Name of contingent beneficiary (last, first and middle initial Tina Quequish	er coverage, should die befiefit that would have been p, then the proceeds will be s of be any surviving beneficial) Date of birth (dd/mmm/) 26-12-1959	ore you. In that event, a co ayable to the primary bene iplit, evenly, amongst the co aries at the time of your de yyyy) Relationship to plan m Mother	ntingent ficiary(ies). ontingent ath, the				
		Name of contingent beneficiary (last, first and middle initia	al) Date of birth (dd/mmm/)	yyyy) Relationship to plan m	nember				
5	Trustee appointment			as Taustee to receive any am	sount due to				
	Complete if any beneficiary named is under the age of majority.	l appoint as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).							
6	Declaration and authorization	<u>I hereby</u> revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the 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 beneficiary designation in this form is as valid as the original.	Lacknowledge 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/yyyyy)							
)- Culque	M	25-04-	2019				