

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.

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|----------|---|---|--|--|--|--|
| 1 | Plan sponsor statement | Plan sponsor name Nishkunber-Hoki Leyd Services Corp Plan contract number 1/80 20 | | | | |
| | | Billing division Account/Division number Plan member's certificate number | | | | |
| | | Do you want the waiting period added to the hire date? Wes ONo Permanent hire date (dd/mmm/yyyy) 30 Apr / C | | | | |
| | | Re-hire date (dd/mmm/yyyy) If a re-hire, date previous employment ended (dd/mmm/yyyy) | | | | |
| | | Occupation Bul Verilication Class Hours worked/week 35 Salary \$ 5000 Frequency Ans | | | | |
| l c | ertify that the plan normal work schedule | nember listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works 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) & 2/May 201 | | | | |
| | | Is evidence of insurability required? • Yes Ano (in order to determine if evidence of insurability is required, please refer to your contract.) | | | | |
| | | If yes, please complete form GL0004E and send to Manuilfe for processing. | | | | |
| : | Plan member information | Plan member's last name Benson First name Charles | | | | |
| | To be completed by | Date of birth (dd/mmm/yyyy) 07/09/1962 Gender (Male) Female . Province of residence UNTAR | | | | |
| | employee | Language (English (French Do you have a spouse? (married, common law or civil union?) (Fres (No | | | | |
| 1 | Plan member | Address (number, street, apt.) 66 Atword | | | | |
| | address | City Sloux Cookeat Province ON Postal code PST-11 | | | | |
| - | For Quebec res | sidents (age 65 or over) Are you participating in the RAMQ drug plan? Yes No | | | | |
| _ i | 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 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 O No Dependant Life may be mandatory. Refer to the policy details. | | | | |
| ì | 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 | | | | |
| ns | sured's last name | First name Date of birth (dd/mmm/yyyy) | | | | |
| Ēf | fective date of covera | ge (dd/mmm/yyyy) Identification/certificate number Policy number | | | | |
| 7), | ease indicate type of | coverage under other plan: Extended Health Benefits Dental Care | | | | |
| in | cases where the infr | ○ Single ○ Single ormation is not complete a ○ Couple ○ Couple | | | | |
| | efault value will be ap | | | | | |
| | | C None C None | | | | |
| | | - | | | | |
| | | | | | | |
| _ | | Continued on the next page | | | | |
| | | · - | | | | |

| 7 Dependant information | Complete the follo | wing section | n if the plan inc verage. | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|---|---|----------|
| *Spouse | Last name | enson | <u> </u> | _ First na | me <u>Mav</u> | jorie An | n Date | e of birti | h (dd/mmm | /yyyy) <u></u> | 4/64/1 | 194 |
| If there is not enough room to list your | Gender OMale | Fem | ale If comm | | C4 | he effective date | | | | | | |
| dependants, attach details on a separate sheet. | **To apply for over | r-age disabl | ed dependant o | coverage, p | lease compl | ete form GL0514 | E. | | | | | |
| Last name | | First name | | | · Date of bi | th (dd/mmm/yyy) | у) | Ge Male | ender Female | Over-age student | Over-age disabled dependant** | |
| | | | | | | | | Ċ | 0 | 0 | 0 | |
| | | | | | - | | | 0 | 0 | 0 | · (C) | |
| | | | | - | | | | 0 | 0 | 0 | 0 | |
| | | | | | | | | 0 | 0 | 0 | 0 | |
| 8 Direct deposit | | | 207 | | | | | | | | | - |
| Complete the following | Transit number | | 387 | | 1 | | | | | | ſ | |
| section if you would like to sign up for direct deposit of your claim | Institution number Bank account num | | -92431 | | 1, 1091, | 12 <u>0 \$ \$ 2 2#546</u> | O: OD | 011=0 | 011111 | <i>;</i> | | |
| payments. | | | | | | | stitution r | | | number | L | |
| Electronic claim statement | By providing your Work email address | , | | | | | | - 1 | | 31312 | . الخيية | _ |
| 9 Authorization a | | 55 <u>~40</u> | CI SOLE YOU | nieger. | COD, CA Per | sonal email addre | ess Ju | מני או | <u> </u> | حهراد اد | Jura | - - |
| hereby apply for cover | | | | | | | | | | | | |
| portion of this Coverage I authorize Manulife to a plan administration, and or organization with Info plan administrator, insure each other and with Maron their behalf as if they deductions from my pay and administration, if my If applicable, I authorize account ("Account") that me and any other finance I understand and agree Payment(s). I also underein, and require my phanulife into the Account Manulife, either by me | collect, use, mainta iit, assessment, inwa imation, including a maintain, including a rer, investigative agroulife, its reinsurers were signing it their for my Group Bensy SIN is used as my a Manulife to depose it have identified or cial institution I chook a that upon the deparstand and agree personal written enot, to which I am now by representative: | in and disclessigation, castigation, canny medical ency, and early and early and early selection its selection its selection it all payment this form, it that Manuli dorsement retentiled, eas of my esta | ose personal in laim managem and health pro my administrato service provider do disclose at applicable. Lauper certificate nonts ("Payments Leonfirm that it in the future; a Payment(s) into future de may, at any telating to future ther by contractate. | formation rent, undervices to other s, for the P and receive thorize the umber. Lac umber. Lac umber de | relevant to thin writing and for facilities or penetral progress. Lar their Informa e use of my \$ tree a photocome from the al ank deposit imain valid ur int, Manuille illhout prior or s), I also her shall not form | s application ("In r determining pla roviders, profess rams to collect, to a authorized by the profess of the Purple to a language of the language of the Purple to a language of the language of the Purple to a language of the Purple to a language of the language | Iformation an eligibilisional regional regional regional regions, main my Deposes. Le Number a version Group Bolies to thiling by mod from a ethe direge and a poerty, and poe | n") for t ity ("Pu julatory ntain ar endants withoriz ("SIN") of this enefits the finan- me, or m my furth tot depo- agree the d shall I | he purpose rposes"). Le bodies, ar hod exchange is to conserte my plan for the purpauthorization policy ("Pocial Instituting duly authorization policy to pay authorization policy ("Pocial Institution policy ("Pocial Institutio | es of Group authorize a by employer, e this inform to the sponsor to poses of ide on is valid. Biey"), into the on herein nadized reprovith respect the ment(s), as rement(s) mailely refunded. | Benefits any person of group nation with horization, make entification he bank hamed by he esentative he such he bank he such he bank | |
| If applicable, <u>Lauthorize</u> <u>understand</u> such correscommunication. <u>Lagree</u> Manulife or by me pursuaddress maintained by <u>Restormer Service Center</u> | spondence may cor that Manulife is not tant to this authoriza Manulife, <u>Lunderst</u> | ntain Inform I liable for d ation, I agre | alion; and that I amages which ! e should the er | the informa I may incur mail addres | ition is being as a result c ss Identified c | sent in a manner f interception by n this form chanc | r that is i a third p oe that I | not gua: arty of : am res | ranteed as an email tr nonsible fo | a secured r insmission : r undation ti | neans of sent by he email | |
| I understand that any Ir disability file. Access to a • Manutife emplo • persons to who • persons author I have the right to reque | my information will byees, representativ om I have granted a rized by law. | be limited to res, reinsure ccess; and | o: ers, and service | providers | in the perfor | nance of their Job | bs; | | · | | alth or | |
| Lacknowledge that more Manulife's Privacy Policy | re specific delails re | egarding ho | w and why Man | ulife collec | ts. uses. mai | ntains, and discle | oses my | person | al informat | | ound in | |
| Plan member signature | Cho | ler | Ben | 20- | · | | · | · | (dd/mmm/) | ₁₇₇₇₎ 3 9/ | 04/20 | 18 |
| 10 Mailing instruc | Manuli PO BO | ife Finan X 11006, | dministrations of the contract | | .E | | | | · | | <u> </u> | - |

Nishnawbe-Aski Legal - vices

807-737-4847

05-01-2018

°;27 a.m.

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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 4TB 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 | ۱ | 'ian member certhicate n | umber |
|---|---|--|---------------------------|--|--|---|-----------------|
| | | Plan member name (last, first and middle Initial) | | Province of residence | | late of birth (dd/mmm/yy) | |
| | | Benson, Charles | | ontone | <u>.</u> | 07/09/19 | 962 |
| 2 | Primary beneficiary | Name of beneficiary (last, first and middle initial) Benson, Marjorie Ann | | f bigh (dd/nmm/yyyy) 104/1964 | | onship to plan member | Percentage 70 % |
| | List all primary beneficiaries for Basic Life and/or Basic Accidental Death. | Name of beneficiary (last, first and middle initial) Bonson Jack Charles | Date o | | Relati | anship to plan member | |
| | Percentages must total 100% to be valid. | Name of beneficiary (last, first and middle initial) Bensar Carring Cathleen | Date d | | Relati | onship to plan member | _ |
| | Irrevocability | | | For Quuebec, the designation o | ebec i if your other inclicia | residents only spouse as beneficiary is wise specified. ary, the designation is: | |
| 3 | Optional coverage (if applicable) | Name of beneficiary (last, first and middle initial) Rae, Wwanda Annotty Yan | • | of birth (dd/mpnm/yyyy) 3/12/1982 | | ionship to plan member | Percentage |
| | Plan contract number | Name of beneficiary (last, first and middle initial) | Date o | of birth (dd/mmm/yyyy) | Relati | ionship to plan member i | Percentaga % |
| | List all beneficiaries for Optional Life and/or Optional Accidental Death. | Name of beneficiary (last, first and middle initial) | Date o | of birth (dd/mmm/yyyy) | | • | Percentage % |
| | Irrevocability | | In Q | uebec, the designation of unless | of your other nelicia | residents only spouse as beneficiary is wise specified. ary, the designation is: | irrevocable |
| 4 | Contingent beneficiary | | | | | | |
| | | Name of contingent beneficiary (last, first and middle initia | l) | Date of birth (dd/mmm/y | ууу) | Relationship to plan me | ember |
| | | Name of contingent beneficiary (last, first and middle initia | i) 1 | Date of birth (dd/mmm/y | 'yyy) | Relationship to plan me | ember |
| 5 | Trustee appointment | | | | | | |
| | Complete if any beneficiary named is under the age of majority. | I appoint | oueb | ec). | as Tr | ustee to receive any amo | ount due to |
| 8 | Declaration and authorization | I hereby revoke any previous beneficiary designati person(s) named above. | ons In | relation to my forego | ing c | overage(s) and design | nate the |
| | Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid. | At Manutife Financial, we know that confidentiality to us will be kept in a Group Life and Health Benefit our employees and service representatives in persons to whom you have granted access; an apersons authorized by law. | its file. The pe Id | Access to your infon rformance of their job | mation ss; | n will be limited to: | · |
| | A copy, fax, scan or image of the beneficiary designation in this form | You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information. | | | | | |
| | is as valid as the original. | <u>I acknowledge</u> that more detailed information con discloses my personal information is available at w plan sponsor. | cemin ww.m | g how and why Manu anulife.ca/planmemb | ilife F er, or | inancial collects, uses by requesting a copy | and from my |
| | | Plan number signature | | | | Date signed (dd/mmm | |
| | | The Som | | | | 30/04/ | NB |



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 | | P | an contract number | |
|--------|--------------------------------|--|---|---|---|---------------------------|
| | | Billing division | Account/Division numb | er Plan m | nember's certificate number | |
| | | Do you want the waiting period a | dded to the hire date? | ○Yes ○ No Per | manent hire date (dd/mmn | n/yyyy) |
| | | Re-hire date (dd/mmm/yyyy) | I | f a re-hire, date previous en | nployment ended (dd/mmn | n/yyyy) |
| | | Occupation | Class | Hours worked/week | Salary \$ | Frequency |
| | | nember listed below is actively at e of at least the set minimum hours | | | | |
| | | Plan administrator signature | | | Date (dd/mmm/yyyy |) |
| | | Is evidence of insurability require | d? ○Yes ○No | | if evidence of insurability is | required, please refer to |
| | | If yes, please complete form GL0 | 004E and send to Manu | your contract.) ulife for processing. | | |
| 2 | Plan member information | Plan member's last name | Benson | Fir | st name_Chov(| 19 |
| | information | Date of birth (dd/mmm/yyyy) | 7/09/1962 | Gender Male Fe | male Province of res | idence ON |
| | To be completed by employee | Language ✓ English ○ Fre | 1 / | e a spouse? (married, com | | |
| 3 | Plan member | Address (number, street, apt.) | 78 Fr. | nie Rood | · · · · · · · · · · · · · · · · · · · | |
| | address | city Wegomon | Cuko | Province O | N Postal code | POU-240 |
| 4 | For Quebec res | sidents (age 65 or over) | | | | |
| _ 5 | Application for | Some plans allow refusal of certa | in honofite if the plan m | ember has coverage under | their enquee's plan. If you | wish to add coverage at |
| | coverage | a later date, you may reapply for | these benefits at which | time satisfactory medical e | vidence may be required. | wish to add coverage at |
| | | I am applying for Extended Healt | h Care for | I am apply | ring for Extended Dental C | are for |
| | | Myself only | | ○ Myse | lf only | |
| | | Myself and 1 dependant (chi | ld or spouse) | Myse | If and 1 dependant (child o | r spouse) |
| | | Myself and 2 or more depend | dants (spouse and child | ren) | If and 2 or more dependan | ts (spouse and children) |
| | | O None, because my spouse h | as coverage | ○ None | , because my spouse has | coverage |
| | | Are you applying for Dependant L | ife? Yes No | Dependant Life may be | mandatory. Refer to the po | licy details. |
| 6 | Coordination of benefits | This section is required if you are Do you or your dependants (spou | applying for coverage of applying for coverage of applying for children) have | on your dependants. e benefit coverage under a | nother benefits plan? | Yes No |
| | | If yes, please provide the following | g details: Name | of other insurer | | |
| Ins | sured's last name | | _ First name | | Date of birth (dd/mmn | n/yyyy) |
| Ef | fective date of covera | ge (dd/mmm/yyyy) | Identification/certific | ate number | Policy | number |
| Ple | ease indicate type of | coverage under other plan: | | Health Benefits | Dental Care | • |
| In | cases where the info | rmation is not complete a | ◯ Singl | | SingleCouple | |
| | efault value will be ap | | ○ Fami | | Couple Family | |
| | | | O None | 5. | O None | |
| | | | | | - | |
| | | | | | | |

| 7 Dependant information | in Section 5 Application for coverage. | cludes health and/or dental coverage and you | | | | |
|---|---|--|--|---|--|--|
| Spouse If there is not enough | Last name Senson | _ First name Marjorie Aun [| | | | 107/11 |
| room to list your dependants, attach | Gender Male Female If comm | non law, please provide the effective date of co | ohabitation | n (dd/mmm/ | уууу) | |
| details on a separate | **To apply for over-age disabled dependant | coverage, please complete form GL0514E. | | | | |
| sheet. Last name | First name | Date of birth (dd/mmm/yyyy) | G Male | ender Female | Over-age student | Over-age disabled |
| Benson | T.A. | | 0 | 0 | 0 | dependant** |
| | | | _ 0 | 0 | 0 | 0 |
| | | | _ 0 | 0 | 0 | 0 |
| | | | _ 0 | 0 | 0 | 0 |
| 8 Direct deposit | Transit number 00387 | | | | | |
| Complete the following | | MEMO | | | | |
| section if you would like to sign up for direct | Institution number 0/0 | " 108" (:01122" 540); (| 00011-0 | 001111 | | |
| deposit of your claim payments. | Bank account number 70 - 92 43 | Transit number Institution | n number | Account | number | |
| Electronic claim | By providing your email address, you will red | ceive an invitation to register for an online men | nber acco | unt. | | |
| statement | Work email address _ bensone Nan | Negal . W . Personal email address_ | Jarr. | shense | ~ 13131 | 3 @ ga |
| 9 Authorization a | | | | | | |
| portion of this Coverage Lauthorize Manulife to plan administration, auc or organization with Infoplan administrator, insure each other and with Ma on their behalf as if they deductions from my pay and administration, if m If applicable, Lauthoriz account ("Account") tha me and any other finant Lunderstand and agree Payment(s). Lalso und | e, and future claims thereunder may be denied collect, use, maintain and disclose personal in dit, assessment, investigation, claim manager ormation, including any medical and health proper, investigative agency, and any administrate unulife, its reinsurers and/or its service provide y were signing it themselves, and to disclose a y for my Group Benefits plan, if applicable. Lar y SIN is used as my plan member certificate in the Manulife to deposit all payments ("Payments It I have identified on this form. I confirm that icial institution I choose to name in the future; age that upon the deposit of any Payment(s) interstand and agree that Manulife may, at any | plete to the best of our knowledge. <u>I acknowled</u> or terminated as a result of the provision of fanformation relevant to this application ("Information, underwriting and for determining plan eligofessionals, facilities or providers, professional ors of other benefits programs to collect, use, rises, for the Purposes. <u>I am authorized</u> by my Dand receive their Information, for the Purposes <u>uthorize</u> the use of my Social Insurance Numbrumber. <u>I agree</u> a photocopy or electronic verses") due to me from the above referenced Grouthis direct bank deposit authorization applies to the Account, Manulife is fully discharged from the and without prior notice, discontinue the terms. | alse, inconation") for gibility ("Pu regulaton maintain a pependant. Lauthoriber ("SIN") ion of this other finar on many furth direct depitation. | nplete, or m the purpose irposes"). L y bodies, ar nd exchang s to conser ze my plan for the pur authorizati policy ("Po icial instituti per liability v osit of Payn | pisleading in as of Group authorize a sylve employer to this Authorize to this Authorize to this Authorize to this Authorize on it sylve employer to poses of ideon is valid. (licy"), into the fon herein norized reprivith respectment(s), as r | formation. Benefits ny person group nation with horization, make ntification he bank amed by eesentative. to such equested |
| Manulife into the Accou Manulife, either by me of | nt, to which I am not entitled, either by contractor by representatives of my estate. | re Payment(s). <u>I also hereby acknowledge ar</u> ct or by law, shall not form part of my property, | and shall | be immedia | ately refunde | ed to |
| understand such corre communication. I agree Manulife or by me pursu | espondence may contain Information; and that that Manulife is not liable for damages which uant to this authorization. I agree should the e Manulife. I understand that if I do not wish to | email address identified on this form regarding the Information is being sent in a manner that I may incur as a result of interception by a thir email address identified on this form change the receive emails from Manulife, I can remove m | is not gua rd party of at I am res | ranteed as an email tra sponsible fo | a secured r ansmission or updating to | neans of sent by ne email |
| disability file. Access to Manulife emple persons to whe persons autho | my Information will be limited to: oyees, representatives, reinsurers, and service om I have granted access; and rized by law. | fe in accordance with this authorization, will be providers in the performance of their jobs; le, and, where appropriate, to have any inaccu | | | | alth or |
| I acknowledge that mo | ore specific details regarding how and why Ma | nulife collects, uses, maintains, and discloses at www.manulife.ca/planmember, or from my | my persor | nal informat | | ound in |
| Plan member signature | Chale Bh- | | | | /// 35/ | 04/2015 |

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) | | Province of residence | Date of birth (dd/mmm/y) | ууу) | | |
| | | Benson Charles | | 02 | 07/09/196 | 2 | | |
| 2 | Primary beneficiary | Name of beneficiary (last, first and middle initial) | Date | of birth (dd/mmm/yyyy) | Relationship to plan member | Percentage | | |
| | List all primary beneficiaries for | Benson, Marjorie Ann Name of beneficiary (last, first and middle initial) | 04 | 1/04/1964 | wite | 70 % | | |
| | Basic Life and/or Basic Accidental Death. | Name of beneficiary (last, first and middle initial) Benson, Jack Charles | Date of | 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) Benson Corme Collegen | Date | of birth (dd/mmm/yyyy) | Relationship to plan member daughter | 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 Q | uebec, the designation of unless | nebec residents only of your spouse as beneficiary is cotherwise specified. eneficiary, the designation is: able Irrevocable | s irrevocable | | |
| 3 | Optional coverage (if applicable) | Name of beneficiary (last, first and middle initial) Rae Muranda Amelle Lym | | of birth (dd/mmm/yyyy) | Relationship to plan member | Percentage | | |
| | Plan contract number | Name of beneficiary (last, first and middle initial) | - | of birth (dd/mmm/yyyy) | Relationship to plan member | Percentage % | | |
| | List all beneficiaries for Optional Life and/or Optional Accidental | Name of beneficiary (last, first and middle initial) | Date | of birth (dd/mmm/yyyy) | Relationship to plan member | Percentage % | | |
| | Death. Irrevocability | Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation. 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 the primary beneficiary(ies), named above for either beneficiary will automatically be entitled to the benefit you name more than one contingent beneficiary, beneficiaries you choose to name. Should there no proceeds will be paid to your estate. Name of contingent beneficiary (last, first and middle initial | er cove efit that then the of be a | erage, should die befo at would have been p he proceeds will be s | ore you. In that event, a col ayable to the primary bene plit, evenly, amongst the co aries at the time of your dea | ntingent ficiary(ies). ontingent ath, the | | |
| | | Name of contingent beneficiary (last, first and middle initia | al) | Date of birth (dd/mmm/y | ryyy) Relationship to plan m | ember | | |
| 5 | Trustee appointment | | | | | | | |
| | Complete if any beneficiary named is under the age of majority. | l appoint any beneficiary under the age of majority (not applicable in | n Queb | ec). | as Trustee to receive any am | ount due to | | |
| 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. | 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. | | | | | | |
| | A copy, fax, scan or image of the beneficiary designation in this form | You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information. | | | | | | |
| | is as valid as the original. | <u>I acknowledge</u> that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor. | | | | | | |
| | | Plan member signature | Date signed (dd/mmm/yyyy) | | | | | |
| | | Clark the | - Angelijne | | 30/4/2018 | | | |

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