

Group retirement plan

Payroll deduction authorization

To be completed by an employee who is eligible to participate in a group retirement plan.

Services for this plan are provided by The Great-West Life Assurance Company (Great-West). The policy is issued by London Life Insurance Company, a subsidiary of Great-West.

Please print.

EMPLOYER/PLAN SPON	ISOR INFORMATION						
Name of employer/plan spo	onsor		Policy/plan number				
NISHNAWBI	E ASKI LEGAL SERVICE	ES CORP	68012				
EMPLOYEE INFORMATION	ON						
Last name	Initial	First name	Social insurance number	Employee I.D.			
STOLE	F	Duraen	48 78 932				
Payroll deduction autiabove plan as follows:	horization – I authorize my	r employer/plan spor	nsor to deduct contributions fo	or remittance to the			
Plan:	□ RRSP □ RPP □ Other	☐ Non-registere	ed 🗌 TFSA 🗌 VRS	SP			
Payroll deduction: (fill in only those applicable)	Contribution Type Regular / required Additional voluntary	Amou	nt to be deducted per pay _% _% _%				
This replaces all previo	us instructions for this grou	p retirement plan.					
Employee signature	Way Stra	_	Date	18			

NOTE: This form is to be retained by the client/plan sponsor, and should not be returned to Great-West Life, Group Retirement Services.

Transmission Report

Date/Time Local ID 1

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10-28-2020 8076221096

17:19:47

Transmit Header Text Local Name 1

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OIRARIO		sib.ca				1	Claim N	lumber	Repo	-
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A. Worker Information ob Title/Occupation (at the time of accident/iliness - do n	ot use abbrevial	tions) Length	of time in	this position		·i	Social I	nsurance	Number	
AO Assessment Officer		while w	voriding far	you	21	yrs				
Please check if this worker is a: executive 🔲 e	lected official	owner		or relative of t				87		
Last Name English				is the worker of Union/Collecti			Worker	Referenc	e Numbe	I.
Stone Doreen	:		L] yes 🛂					
Address (number, street, apt., suits, unit)				Worker's prefe			Date of Birth	dd d	mm 0 1	7
137 Raindeer Ave			ll ll	English L Other	Frenc	'n	7elepho		UI	
City/Town Prov			ľ					2214	13	
Thunder Bay ON	P7C8	AS .	ŀ	Sex	1 1-2		Date of	dđ	mm	yy
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3. Employer Information									Гоld #10-	hora for esvelo;
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lishnawbe-Aski Legal Services C	orporatio	n		L Number Subclass		kumber NAICS ('oria			
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City/Town		Province	Postal			Tefepho				
Thunder Bay		ON		2R6			622-1	413		
Description of Business Activity		Does you more wo	ur finn have ukers?		П.,	FAXING	nber 32230	24		
ndigenous Legal Services Tranch Address where worker is based (If different from ma	Ilino aridrese			✓ yes	100	burt	2230	24		
National Leagues and Market in present in authorise and its and	mile manitary		-7							
City/Town		Province	Postal	Code		Alternat	e Teleph	020		
C. Accident/Illness Dates and Details										
A WATHOUNG HOUSES IN SING MOTHER										
1. Date and hour of dd m/n yy		AM 2. Who w	vas the acc	ident/Biness re	ported to	? (Name	& Post	ion)		
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Duration Mode Job Type Results **Remote Station** Start Time Pages Line No. doL 17:11:45 10-28-2020 CP14400 001 924 WSIB 00:04:31 4/4 HS

Abbreviations:

HS: Host send HR: Host receive WS: Waiting send PL: Polled local PR: Polled remote MS: Malibox save MP: Mallbox print RP: Report

FF: Fax Forward

CP: Completed FA: Fall

TS: Terminated by system G3: Group 3

TU: Terminated by user

EC: Error Correct



Mail To: 200 Front Street West Toronto ON M5V 3J1

OR Fax To: 416-344-4684 OR 1-888-313-7373

Toll free: 1-800-387-0750 TTY: 1-800-387-0050 wsib.ca

Employer's Report of Injury/Disease (Form 7)

Claim Number

Please	PRINT in bl	ack ink								- 1						- 1
A. Worker Information																=
Job Title/Occupation (at the time o		s - do not use	abbreviat	tions)		th of time in working fo		tion	21 y		Social	Insur	ance N	lumber		
Please check if this worker is a:	executive	elected	d official		owner	spou	se or relat	ive of the e	mployer	4	4 8	8	7 3	3 9	3	2
Last Name	I Accessed	t Name						rker covere ollective Ag		t?	Vorke	r Refe	rence	Numbe	r	
Stone		oreen					Worker's	s preferred	languag	е	Date o		dd	mm	уу	
Address (number, street, apt., st 137 Raindeer Ave	inte, unit)						✓ Engl		rench	<u> </u>	Birth	1	4	0 1	7	1
City/Town		Province	Postal C	ode			Othe	er			Teleph		2141	3		
Thunder Bay		ON	P7C6	A6									dd	mm	уу	\dashv
V		•••••		•••••			Sex	М	✓ F		Date o		3 0	0 9	9	
B. Employer Information	l						$\overline{}$								here fo envelor	
Trade and Legal Name (if different Nishnawbe-Aski Leg	provide both)	es Corp	oratio	n		Check one:		m OR [ount iber	Provid	de Nu	mber			-
Mailing Address			Tel-to-to-to-to-to-to-to-to-to-to-to-to-to-	200		Class	/Subclass	S	NA	ICS C	ode					
1805 Arthur Street E	ast															4
City/Town				Provi		150,000,000	l Code E 2R6			ephor	e 22-	1/1	3			
Thunder Bay				ON	-					X Num		141				-
Description of Business Activity Indigenous Legal Se	rvices					our firm ha workers?		yes 🗌	. 233		223	024				
Branch Address where worker is ba	OHIL BIOCESTINGS	rom mailing	address -	no abl	oreviatio	ons)										\neg
	S. S															
City/Town				Provi	nce	Post	al Code		Alt	emate	Telep	hone				
C. Accident/Illness Date	es and Deta	ils										science in				_
1. Date and hour of accident/Awareness of illness 2	•••	0 2	2:20	AM PM		o was the a										
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5. Area of Injury (Body Part) - (PI Head Teeth Face Neck Eye(s) Chest Ear(s) Other	Uppe	er back er back omen	Left Sho	oulder rm bow earm	Right	Left	Wrist Hand Finger(s)	Right	Left	Hip Thig Knee Lower	n	Right	Lef	Ankl Foo Toe	t 🗀	nt]
6. Describe what happened to ca etc). Include what the injur	use the accident,	ils of equipm	ent, mate	rials. e	environn	ng at the tin nental cond Ily over t	itions (wo	rk area, ten	nperatur	e, nois	e, cne	emica	ı, gas,	lumes	other	



7	Employer's Report of injury or Illness (Form 7)
	Claim Number

Please PRINT in black ink

Worker Name	Social Insurance Number
Stone Doreen	4 8 8 7 3 3 9 3 2
C. Accident/Illness Dates and Details (Continued)	
Constitution (short floor wavelenges plien	t/customer site, parking lot, etc).
7. Did the accident/lilness happen on the employer's premises (owned, leased or maintained)? yes no outside the back of the bu	
8. Did the accident/illness happen outside the Province If yes, where (city, province/state, country	
of Ontario?	
9. Are you aware of any witnesses or other employees If yes, provide name(s), position(s), and w	vork phone number(s).
involved in this accident/illness?	
2	
10. Was any individual, who does not work for your firm, partially or totally responsible for this	one number
accident/illness?	
11. Are you aware of any prior similar or related problem, injury or condition?	
yes 🗹 no	
12. If you have concerns about this claim, attach a written submission to this form.	tached
D. Health Care	
1. Did the worker receive health care for this injury? dd mm yy 2. When did the employed	yer learn that the worker dd mm yy
yes no If yes , when:	
3. Where was the worker treated for this injury? (Please check all that apply)	
On-site health care Ambulance Emergency department Admitted to hosp	oital Health professional office Clinic
Other:	
Name, address and phone number of health professional or facility who treated this worker (if known).	
E. Lost Time - No Lost Time	
1. Please choose one of the following indicators. After the day of accident/awareness of illne	
Returned to his/her regular job and has not lost any time and/or earnings. (Complete section Returned to modified work and has not lost any time and/or earnings. (Complete sections	
Has lost time and/or earnings. (Complete ALL remaining sections).	, .,,,
dd mm yy	dd mm yy
Provide date worker first lost time Date worker returned to work (if	
2. This Lost Time - No Lost Time - Modified Work information was confirmed by:	Telephone Ext.
Mysalf Other	807-622-1413 7714
Maille	<u> </u>
F. Return To Work	If you would be a second
1. Have you been provided with work limitations for this worker's injury? 2. Has modified work been discussed with this worker? 3. Has modified work been offered to this worker?	If yes, was it Accepted Declined
□ yes ☑ no □ yes ☑ no □ yes ☑ no	o If Declined please attach a copy of the written offer given to the worker.
4. Who is responsible for arranging worker's return to work	Telephone Ext.
Myself Other	I Elebandie
Name	
0007A (01/20)	Page 2 of 4



Employer's Report of Injury/Disease (Form 7)

Claim	Number	

Please PRINT in black ink Social Insurance Number Worker Name 488733932 Doreen Stone G. Base Wage/Employment Information - (Do not include overtime here) 1. Is this worker (Please check all that apply) Owner Operator or (Sub) Contractor Registered Apprentice Casual/Irregular Student **Permanent Full Time Optional Insurance** Permanent Part Time Seasonal Unpaid/Trainee Contract Temporary Full Time Other **Temporary Part Time** 2. Regular rate of pay □ day other week \$29.67 hour per **H. Additional Wage Information** Provide 2. Vacation pay 1. Net Claim Code percentage - on each cheque? or Amount Provincial Federal yes 🗸 no 6. Normal earnings for 5. Actual earnings for 4. Normal working hours on 3. Date and hour last worked last day worked last day worked last day worked dd mm From W 9:00 AM 5:00 AM \$ 5:00 PM PM 1 0 2 0 2 7 PM Advances on wages: If yes, indicate: Full/Regular yes Ino Is the worker being paid while he/she recovers? 8. Other Earnings (Not Regular Wages): Provide the total of additional earnings for each week for the 4 weeks before the accident/illness. Use these spaces for any other earnings * For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..). cycle prior to the date of accident/illness. Voluntary Mandatory From Date Commission Commission Commission Commission Period Overtime Pay (dd/mm/yy) Overtime Pay (dd/mm/yy) \$ \$ \$ \$ \$ Week 1 \$ Week 2 \$ \$ \$ \$ \$ \$ \$ \$ Week 3 \$ \$ Week 4 I. Work Schedule (Complete either A, B or C. Do not include overtime shifts) Example: Monday to Friday, 40 hours (A.) Regular Schedule - Indicate normal work days and hours. S M T W T F S 8 8 8 8 8 Saturday Wednesday Thursday Friday Sunday Monday Tuesday 7 7 (B.) Repeating Rotational Shift Worker - Provide NUMBER OF WEEKS NUMBER OF HOURS NUMBER OF DAYS OFF PER SHIFT(s) IN CYCLE DAYS ON Example: 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle. Varied or Irregular Work Schedule - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here). Week 4 Week 2 Week 3 Week 1 From/To Dates (dd/mm/yy) **Total Hours Worked Total Shifts Worked** J. It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1, 2, and 3 is true. Name of person completing this report (please print) Official title **Human Resources Manager Colette Shwetz**

Telephone

807-622-1413

Signature

уу

mm

281020

dd

Date

Ext.

7714



Worker Name

Please PRINT in black ink

7

Employer's Report of Injury/Disease (Form 7)

Claim Number

Social Insurance Number

Stone	Doreen	4 8 8 7 3 3 9 3 2
K. Additional Information		



August 11, 2022 CONFIDENTIAL

COPY

Doreen Stone 137 Reindeer Ave Thunder Bay ON P7C 6A6



Dear Doreen Stone,

Re: Firm # 59086 - NISHNAWBE-ASKI LEGAL SERVICES CORP. Certificate # 68931 - Over Age Dependent Child - Cameron

According to our records, Cameron will soon reach the maximum age for Dependent children (age 21) under your group plan.

This is in reference to the dependent child eligibility requirements under CINUP.

Dependent children are eligible under CINUP if they are the employee's own natural offspring and lawfully adopted or adopted by custom children. Stepchildren, foster children and other children who are dependent on the employee for support and living with the employee in a regular parent-child relationship are also eligible.

All children must be unmarried, under the age of 21 and dependent on you for support or unmarried and under the age of 26 and in full-time attendance at a school, college or university.

In order to have your dependent child added to your group insurance plan we require the following:

- Completion of the attached Confirmation of Student Attendance form

Should you have any questions, please contact our office at 1-800-665-1234.

Sincerely,

Tim Essex JG Benefits

Enclosure

cc. NISHNAWBE-ASKI LEGAL SERVICES CORP.



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

		Class
1	Plan sponsor statement	Plan sponsor name Nishnaube 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)
		Do his date (dd/mmm/vyw)
		Occupation Legal Ar & Axencett Steer Hours worked/week 35 Salary \$48 215 60 Frequency Angue
10	ertify that the plan n	nember 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	e 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) 10 / 5 an / 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 STONE First name DORFEN
	illioilliation	Date of birth (dd/mmm/yyyy) 14 01 1971 Gender Male Female Province of residence ONT
	To be completed by employee	Language English French Do you have a spouse? (married, common law or civil union?) Yes
3	Plan member	Address (number street ant.) 511 McMaster Street
	address	Address (Hallinger, Street, apr.)
_		City Thurder Buy Province ON Postal code PICSNI
4	For Quebec re	sidents (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 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 ONo 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? Yes No
		If yes, please provide the following details: Name of other insurer Claim Scure
In	sured's last name	STONE First name KEVIN Date of birth (dd/mmm/yyyy) 35/05/19/4
Ef	fective date of covera	ge (dd/mmm/yyyy) Identification/certificate number 371140 656 Policy number 37114
PI	ease indicate type of	coverage under other plan: Extended Health Benefits Dental Care
In	cases where the info	Single Single Couple
	efault value will be ap	
		○ None ○ None

Continued on the next page

7 Dependant information	Complete the follo	owing section if the	ge.		I coverage and you ha				r dependants
Spouse'	Last name	192 312 015 31 TOUR INC. (002		me	Dat	te of birth	(dd/mmm	n/yyyy)	
If there is not enough room to list your	Gender O Male	e	If common law, ple	ase provide th	e effective date of coh	abitation (dd/mmm/	(yyyy)	
dependants, attach details on a separate	**To apply for ove	r-age disabled de	ependant coverage, p	lease complet	e form GL0514E.				
sheet. Last name		First name			n (dd/mmm/yyyy)		nder Female	Over-age student	Over-age disabled
STONE		CAMER	201)	041	10/2001	0	\bigcirc	\circ	dependant**
STONE		CARSO	N	24/1	5/2013	9	\circ	0	0
<u></u>	=	-		-		0	\circ	0	0
						0	0	\circ	0
8 Direct deposit Complete the following section if you would	Transit number	0050	1						
like to sign up for direct deposit of your claim payments.		Cold Object to the	539		number Institution			number	
Electronic claim statement		•			ter for an online memb			14 0.1	1-1 00
	Work email addre	ss Stone	at 0190.01	1.Ca Perso	onal email address	600	540	Trall	tel ine
9 Authorization	and consent								
provided by me, and/or portion of this Coverage Lauthorize Manulife to plan administration, auc or organization with Infoplan administrator, insule each other and with Ma on their behalf as if they deductions from my pay and administration, if m If applicable, Lauthoriz account ("Account") thame and any other finance Lauthoriz and Lauth	e, and future claims collect, use, mainta dit, assessment, invormation, including rer, investigative agnulife, its reinsurers were signing it the formy Group Ben y SIN is used as man and a greet in the formy Group Ben to the formy Group Ben to the formy Group Ben to the deposit of the formy Group Ben to the deposit of the formy Group Ben to the deposit of the form	thereunder may ain and disclose prestigation, claim any medical and gency, and any acts and/or its service meselves, and to effits plan, if applity plan member consit all payments (in this form. I concose to name in the posit of any Payma that Manulife may be the most of any estate. It is spond with me the intain Information to talliable for damag tation. I agree sh	be denied or terminal personal information in management, underwhealth professionals, dministrators of other ce providers, for the P disclose and receive icable. Lauthorize the ertificate number. Lag "Payments") due to mistim that this direct benefuture; and shall rement(s) into the Accouncy, at any time and wing to future Payment(by contract or by law, arough the email address; and that the Informatics ges which I may incursiould the email addressions.	ted as a result relevant to this writing and for facilities or proposes. Lam their Informatic e use of my Sogree a photocome from the aboank deposit at main valid untimit, Manulife is ithout prior not (s). Lalso here shall not form the side is identified of as a result of side identified or side i	of the provision of fals application ("Informati determining plan eligible by ders, professional reams to collect, use, ma authorized by my Depon, for the Purposes. I locial Insurance Number by or electronic version by effective and in the property of th	se, incompon") for the control of th	polete, or male purpose poses"). I bodies, ai dexchang to conser my plan for the purpose my plan for the purpose for the purpose my plan for plan for the purpose my plan for the my plan for	nisleading ir es of Group authorize in yemployeinge this informat to this Aurisponsor to poses of ide ion is valid. Dicy"), into the ion herein report the ion herein respectment(s), as yement(s) as yement in the Purposes is a secured in ansmission or updating in the group in the ion hereing in the purposes in the purpose in the	soformation. Benefits any person r, group mation with thorization, make entification he bank named by resentative. It to such requested ade by ed to se. L means of sent by the email
	my Information will oyees, representati om I have granted a rized by law.	be limited to: ves, reinsurers, a access; and	and service providers	in the perform	ance of their jobs;				alth or
I acknowledge that mo	re specific details r	egarding how an	d why Manulife collec	cts, uses, main	tains, and discloses m	y persona	al informa		found in
Manulife's Privacy Police	1/200	mation Package,	, available at www.ma	nulife.ca/planr				h	18/15
Plan member signature		Jombor Admi	injetration		Date	e signed (ad/mmm/	уууу)	(10/10
10 Mailing instruc	Manul PO BO	Member Adm life Financial DX 11006, ST REAL QC H	N CENTRE-VILL	.E					

The Manufacturers Life Insurance Company

Page 2 of 4

GL2971E (06/2015) GP/MC

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	F	Plan member certificate n	umber			
		Plan member name (last, first and middle initial) STONE DORREN F		Province of residence	C	Date of birth (dd/mmm/yy)	yy) 7 /			
2	Primary beneficiary List all primary beneficiaries for Basic Life and/or Basic Accidental Death. Percentages must total 100% to be valid.	Name of beneficiary (last, first and middle initial) Name of beneficiary (last, first and middle initial) Source Cameron Name of beneficiary (last, first and middle initial) Name of beneficiary (last, first and middle initial)	Date of	of birth (dd/mmm/yyyy) of birth (dd/mmm/yyyy) of birth (dd/mmm/yyyy) of birth (dd/mmm/yyyy)	Relat	ionship to plan member ionship to plan member ionship to plan member	33 %			
	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 of you unless other		of your other neficia	c residents only ur spouse as beneficiary is irrevocable erwise specified. ciary, the designation is: Irrevocable				
3	Optional coverage (if applicable)	Name of beneficiary (last, first and middle initial) Date of birth (dd/mmm/y		of birth (dd/mmm/yyyy)	Relat	tionship to plan member	Percentage %			
	Plan contract number	Name of beneficiary (last, first and middle initial)	Date o	of birth (dd/mmm/yyyy)	Relat	tionship 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) Re				Relat	tionship 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 Q	uebec, the designation o unless	of your other enefici	c residents only ur spouse as beneficiary is irrevocable envise specified. ciary, the designation is: Irrevocable				
4	Contingent beneficiary	You may wish to designate a contingent beneficiary(ies) to receive any the primary beneficiary(ies), named above for either coverage, should beneficiary will automatically be entitled to the benefit that would have If you name more than one contingent beneficiary, then the proceeds beneficiaries you choose to name. Should there not be any surviving be proceeds will be paid to your estate. Name of contingent beneficiary (last, first and middle initial) Date of birth (definition)			ore you ayable olit, e aries a	ou. In that event, a con e to the primary benef venly, amongst the co	ntingent ficiary(ies). ntingent oth, the			
		Name of contingent beneficiary (last, first and middle initia	al) [Date of birth (dd/mmm/y	ууу)	Relationship to plan me	ember			
5	Trustee appointment Complete if any beneficiary named is under the age of majority.	I appoint ALBERT DRAKE any beneficiary under the age of majority (not applicable in		ec).	as Tr	rustee to receive any amo	ount due to			
6	Declaration and authorization	I hereby revoke any previous beneficiary designate person(s) named above.	ions 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. A copy, fax, scan or image of the	At Manulife Financial, we know that confidentiality to us will be kept in a Group Life and Health Benet • our employees and service representatives in • persons to whom you have granted access; at • persons authorized by law. You have the right to request access to the person	fits file. the per nd	Access to your inform formance of their job	nation s;	n will be limited to:				
	beneficiary designation in this form is as valid as the original.	information. Lacknowledge that more detailed information con discloses my personal information is available at with plan sponsor.	cerning	g how and why Manu	life Fi	inancial collects, uses	and			
		Plan member signature				Date signed (dd/mmm/	() () ()			

7 Dependant information	Complete the folio			and/or dental coverage and you ha	ive not ref	used ben	efits for you	r dependants
Spouse	Last name			ne Da	te of birth	(dd/mmm	i/vvvv)	
If there is not enough room to list your	Gender () Male	_		se provide the effective date of coh				
dependants, attach details on a separate	"To apply for ove	r-age disabled d	ependant coverage, pl	ease complete form GL0514E				
sheet. Last name		First name		Date of birth (dd/mmm/yyyy)		nder Female	Over-age student	Over-age disabled
STONE		CAMER	CON	OH 110 12001	8	0	0	dependant**
		CARSO	N .	a4/05/2013	2	0	0	0
		155 A			0	0	. 🔾	0
				***	0	0	0	0
8 Direct deposit	Transit number	0050	7		*******			
Complete the following section if you would	Institution number	00		MEMO				
like to sign up for direct deposit of your claim	Bank account nun	nber 3105	53A	Transit number institution			number	1
payments. Electronic claim	By providing your	email address, y	ou will receive an invit	ation to register for an online memb		NEW TOTAL CONTRACTOR	Humber	
statement	Work email addre	ss Stone	of olao.on	Ca Personal email address	boot	5/0	Hay	tel ne
9 Authorization a	and consent				-		·	
i authorize Manulife to plan administration, aud 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, Lauthorizacount ("Account") that me and any other finance Payment(s). Latso understand and agree Payment(s). Latso undersin, and require my Manulife into the Account Manulife, either by me of the plant of the Account Manulife, either by me of the Account of the Account Manulife, either by me of the Account of the Account Manulife, either by me of the Account of the Account Manulife, either by me of the Account of the Accou	collect, use, mainta iit, assessment, inv rmation, including a rer, investigative ag nullife, its reinsurers were signing it the r for my Group Beni y SIN is used as my a Manulife to depos I I have identified o cial institution I choo g that upon the depo- ratand and agree personal written end it, to which I am no or by representative	in and disclose; estigation, claim any medical and ency, and any at a and/or its servic meetives, and to effits plan, if applicy plan member of all payments (in this form. I corpose to name in thosit of any Paym that Manuitie medorsement relating tentitled, either is of my estate.	personal information re management, underwishealth professionals, if dministrators of other be providers, for the Pudisclose and receive the disclose and receive the disclose and receive the disclose and receive the entificate number. Lagr "Payments") due to me aftern that this direct bate future; and shall rement(s) into the Accountary, at any time and withing to future Payment(s) by contract or by law, so	d as a result of the provision of fals levant to this application (*Informati titing and for determining plan eligib actities or providers, professional re enests programs to collect, use, ma rposes. <u>I am authorized</u> by my De, leir Information, for the Purposes. <u>I</u> use of my Social Insurance Number as a photocopy or electronic version from the above referenced Group ink deposit authorization applies to lain valid until revoked in writing by I, Manutife is fully discharged from the cout prior notice, discontinue the di- tals of termining acknowledge and thall not form part of my property, and thall not form part of my property, and	on") for the state of the state	e purpose poses"). L odies, ard e exchang to consen my plan or the purp uthorizatio cilicy ("Pol al instituti r duly auty til tof Paym at any Pay a immedia	es of Group authorize a ny employer e this inform to this Auti sponsor to poses of ide on is valid. licy"), into the on herein in norized repro- vitle respect ent(s), as in ment(s) ma stely refunda	Benefits Iny person group group horization, make entification as bank amed by esentiative. to such equested de by ad to
understand such correction. Lauren Manulife or by me pursu	spondence may con that Manulife is no part to this authoriz Manulife. <u>Lunderst</u>	ntain information t liable for dama ation. <u>Lagres</u> sh	r; and that the Informati ges which I may incur a could the email address	ss identified on this form regarding r ion is being sent in a manner that is as a result of interception by a thint is dentified on this form change that its from Manulife, I can remove my a	not guara party of a I am resp	inteed as n email tra onsible fo	a secured rensmission :	neans of sent by he email
disability file. Access to Manufile emplo persons to who persons author	my information with pyees, representation om I have granted a ized by law.	be limited to: ves, reinsurers, a access; and	and service providers in	nce with this authorization, will be ke the performance of their jobs; e appropriate, to have any inaccura	•	•	-	alth or
Lacknowledge that mo	re specific details n	garding how an	d why Manulife collects	, uses, maintains, and discloses m ulife.ca/planmember, or from my Pla	y persona	informati		ound in
Plan member signature	MADIE	Monu	Page 1	Date	signed (d	id/mmm/y	m a	118/18
10 Mailing Instruc	Manul PO BO	lember Admi ife Financial IX 11006, ST REAL QC H	N CENTRE-VILLE				0	•

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 11005, STN CENTRE-VILLE
MONTREAL QC H3C 478
Fax: 1-877-733-4233

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

-			-		
1	Plan member Information	Pten sponsor name	Plan contract number	Plan member certificate nu	umbor
		Nishnaube-18 Ry Case	<i>Y</i>	5.4. 41: m. 44.	_
		Plan member name (test, first and middle initial)	Province of residence	Date of birth (dd/mmm/yyy	y) 1 <i>f</i>
enne		SIDIOC TORRED F	UN	14/01/19	11
2	Primary beneficiary	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan mamber	Percentage
14	List all primary beneficiaries for	Name of beneficiary (last, first and middle initial)	Dale of birth (dd/rmm/yyyy)	Relationship to plan member	Damasiana
	Basic Life and/or Basic Accidental Death.	STAVE CHAMBRON B	10000	SW)	22.33
	Percentages must total 100% to	Name of beneficiary (lest, first and middle initial)	Date of birth (dd/rpmm/yyyy)	Relationship to plan member if	Percentage
	be valid.	STONE CARSON D	24 105/2013	SON	333
	Irrevocability	Note: if beneficiary is shown as irrevocable,		sebec residents only of your spouse as beneficiary is i	
		his/her consent is required to change it. Include a signed and dated consent with this form. You	unless	otherwise specified.	LINAOCUDIO.
		are responsible for ensuring the validity of your designation.		eneficiary, the designation is:	
			○ Revoc		
3	Optional coverage (if applicable)	Name of beneficiary (test, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member F	Percentage
		Name of beneficiary (tast, first and middle initial)	Onto of high radio	D	SH-
	Plan contract number	warts of belieuclasy (asc, inst and middle midar)	Date of Dilet (datatimmyyyy)	Relationsh p to plan member F	'ercentage
		Name of beneficiary (tast, first and middle initial)	Date of high (dd/mmmhwww)	Relationship to plan member if	79 Onninano
	List all beneficiaries for Optional Life and/or Optional Accidental		Date of Both (optioning) ///	reconcitions to prost memoral in	%
	Death.	Note: If beneficiary is shown as irrevocable,			
	Irrevocability	his/her consent is required to change it. Include		lebec residents only of your spouse as beneficiary is in	rrevocable
		e signed and dated consent with this form. You are responsible for essuring the validity of		otherwise specified. Inclicion, the designation is:	
		your designation.	∩ Revoca		
4	Contingent beneficiary	You may wish to designate a contingent beneficiary the primary beneficiary(les), named above for either beneficiary will automatically be entitled to the beneficiary will automatically be entitled to the beneficiary will automatically be entitled to the 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	r coverage, should die befo efit that would have been pu then the proceeds will be s it be any surviving beneficie	ne you. In that event, a continyable to the primary benefic offit, eventy, amongst the contres at the time of your death	ngent lary(ies) lingent i, the
		Name of contingant beneficiary (leat, first and middle initial	Date of birth (dd/mmm/y	(yy) Relationship to plan mem	nber
_					
5	Trustee appointment	1 appoint ALPERT DRAKE			
	Complete if any beneficiary named is under the age of majority.	any baneficiary under the age of majority (not applicable in	Quabsc).	as Trustee to receive any amoun	nt due to
6	Declaration and authorization	Literaty revoke any previous beneficiary designation person(s) named above.	ons in relation to my foregoi	ng coverage(s) and designal	le the
	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 to us will be kept in a Group Life and Health Benefit our employees and service representatives in the parsons to whom you have granted access; and persons authorized by law.	is file. Access to your inform he performance of their jobs	sation will be limited to:	provide
	A copy, fax, scan or image of the benaficiary designation in this form	You have the right to request access to the persons information.	i information in your file and	d, if necessary, correct any in	naccurate
	is as valid as the original.	Lacknowledge that more detailed information cond	eming how and why Manul	le Financial collects, uses ar	nd
		discloses my personal information is available at we	ww.manuilfe.ca/planmembe	r, or by requesting a copy fro	m my
		discloses my personal information is available at wi	ww.manuilfe.ca/planmembe	r, or by requesting a copy fro	m my