THE Great-West Life ASSURANCE COMPANY

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 SPONSOR INFORMATION

Name of employer/plan sponsor	Policy/plan number
NISHNAWBE ASKI LEGAL SERVICES CORP	68012

EMPLOYEE INFORMATION

Last name	Initial	First name	Social insurance number	Employee I.D.
STONE	B	Doreen	488 - 783 - 932	

Payroll deduction authorization – I authorize my employer/plan sponsor to deduct contributions for remittance to the above plan as follows:

Plan: ☐ RRSP ☒ RPP ☐ Non-registered ☐ TFSA ☐ VRSP
☐ Other _____

Payroll deduction: (fill in only those applicable)

Contribution Type	Amount to be deducted per pay
Regular / required	6 %
Additional voluntary	____ %
_____	____ %

This replaces all previous instructions for this group retirement plan.

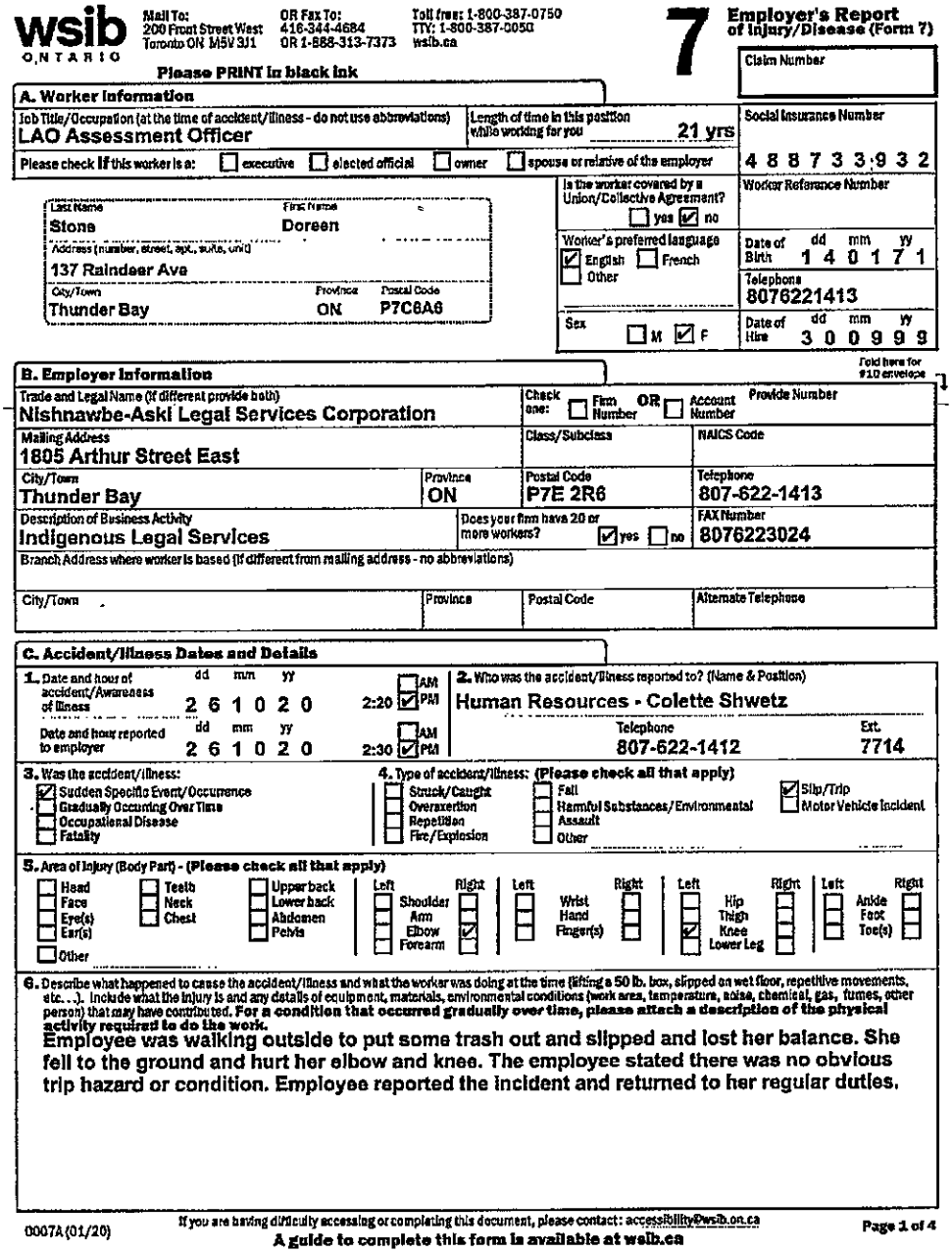
Employee signature Doreen Stone Date May 1/18

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	10-28-2020	17:19:47	Transmit Header Text	
Local ID 1	8076221096		Local Name 1	nalsc

This document : Confirmed
(reduced sample and details below)
Document size : 8.5"x11"



wsib ONTARIO

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

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

Please PRINT in black ink

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations): LAO Assessment Officer

Length of time in this position while working for you: 21 yrs

Social Insurance Number: 488733932

Please check if this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name: Stone | First Name: Doreen

Address (number, street, apt., suite, unit): 137 Raindeer Ave

City/Town: Thunder Bay | Province: ON | Postal Code: P7C6A6

Is the worker covered by a Union/Collective Agreement? ☐ yes ☑ no

Worker Reference Number:

Worker's preferred language: ☑ English ☐ French ☐ Other

Date of Birth (dd mm yy): 14 01 71

Telephone: 8076221413

Sex: ☐ M ☑ F

Date of Hire (dd mm yy): 30 09 99

Fold here for #10 envelope

B. Employer Information

Trade and Legal Name (if different provide both): Nishnawbe-Aski Legal Services Corporation

Check one: ☐ Firm Number OR ☐ Account Number — Provide Number:

Mailing Address: 1805 Arthur Street East

Class/Subclass:

NAICS Code:

City/Town: Thunder Bay | Province: ON | Postal Code: P7E 2R6 | Telephone: 807-622-1413

Description of Business Activity: Indigenous Legal Services

Does your firm have 20 or more workers? ☑ yes ☐ no

FAX Number: 8076223024

Branch Address where worker is based (if different from mailing address - no abbreviations):

City/Town | Province | Postal Code | Alternate Telephone

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness: dd mm yy: 26 10 20 — 2:20 ☐ AM ☑ PM

Date and hour reported to employer: dd mm yy: 26 10 20 — 2:30 ☐ AM ☑ PM

2. Who was the accident/illness reported to? (Name & Position): Human Resources - Colette Shwetz

Telephone: 807-622-1412 | Ext.: 7714

3. Was the accident/illness:
☑ Sudden Specific Event/Occurrence
☐ Gradually Occurring Over Time
☐ Occupational Disease
☐ Fatality

4. Type of accident/illness: (Please check all that apply)
☐ Struck/Caught
☐ Overexertion
☐ Repetition
☐ Fire/Explosion
☐ Fall
☐ Harmful Substances/Environmental
☐ Assault
☐ Other
☑ Slip/Trip
☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - (Please check all that apply)
☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s) ☐ Other
☐ Teeth ☐ Neck ☐ Chest
☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis
Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm | Right ☑ Elbow
Left ☐ Wrist ☐ Hand ☐ Finger(s) | Right ☐ Wrist ☐ Hand ☐ Finger(s)
Left ☑ Hip ☑ Thigh ☑ Knee ☐ Lower Leg | Right ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg
Left ☐ Ankle ☐ Foot ☐ Toe(s) | Right ☐ Ankle ☐ Foot ☐ Toe(s)

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

Employee was walking outside to put some trash out and slipped and lost her balance. She fell to the ground and hurt her elbow and knee. The employee stated there was no obvious trip hazard or condition. Employee reported the incident and returned to her regular duties.

0007A (01/20) If you are having difficulty accessing or completing this document, please contact: accessibility@wsib.on.ca
A guide to complete this form is available at wsib.ca

Page 1 of 4

Total Pages Scanned : 4 Total Pages Confirmed : 4

No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results
001	924	WSIB	17:11:45 10-28-2020	00:04:31	4/4	1	G3	HS	CP14400

Abbreviations:

HS: Host send	PL: Polled local	MP: Mailbox print	CP: Completed	TS: Terminated by system
HR: Host receive	PR: Polled remote	RP: Report	FA: Fail	G3: Group 3
WS: Waiting send	MS: Mailbox save	FF: Fax Forward	TU: Terminated by user	EC: Error Correct

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

Claim Number

Please PRINT in black ink

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations): **LAO Assessment Officer**

Length of time in this position while working for you: **21 yrs**

Social Insurance Number: **4 8 8 7 3 3 9 3 2**

Please check **if** this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name: **Stone** First Name: **Doreen**

Address (number, street, apt., suite, unit): **137 Raindeer Ave**

City/Town: **Thunder Bay** Province: **ON** Postal Code: **P7C6A6**

Is the worker covered by a Union/Collective Agreement? ☐ yes ☑ no

Worker Reference Number:

Worker's preferred language ☑ English ☐ French ☐ Other

Date of Birth (dd mm yy): **1 4 0 1 7 1**

Telephone: **8076221413**

Sex ☐ M ☑ F

Date of Hire (dd mm yy): **3 0 0 9 9 9**

Fold here for #10 envelope

B. Employer Information

Trade and Legal Name (if different provide both): **Nishnawbe-Aski Legal Services Corporation**

Check one: ☐ Firm Number **OR** ☐ Account Number — Provide Number:

Mailing Address: **1805 Arthur Street East**

Class/Subclass:

NAICS Code:

City/Town: **Thunder Bay** Province: **ON** Postal Code: **P7E 2R6** Telephone: **807-622-1413**

Description of Business Activity: **Indigenous Legal Services**

Does your firm have 20 or more workers? ☑ yes ☐ no

FAX Number: **8076223024**

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town: Province: Postal Code: Alternate Telephone:

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness (dd mm yy): **2 6 1 0 2 0** 2:20 ☐ AM ☑ PM

Date and hour reported to employer (dd mm yy): **2 6 1 0 2 0** 2:30 ☐ AM ☑ PM

2. Who was the accident/illness reported to? (Name & Position): **Human Resources - Colette Shwetz**

Telephone: **807-622-1412** Ext.: **7714**

3. Was the accident/illness:
- ☑ Sudden Specific Event/Occurrence
- ☐ Gradually Occurring Over Time
- ☐ Occupational Disease
- ☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
- ☐ Struck/Caught
- ☐ Overexertion
- ☐ Repetition
- ☐ Fire/Explosion
- ☐ Fall
- ☐ Harmful Substances/Environmental
- ☐ Assault
- ☐ Other
- ☑ Slip/Trip
- ☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**
- ☐ Head
- ☐ Face
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Other
- ☐ Teeth
- ☐ Neck
- ☐ Chest
- ☐ Upper back
- ☐ Lower back
- ☐ Abdomen
- ☐ Pelvis
- Left / Right: ☐ Shoulder ☐ Arm ☑ Elbow ☐ Forearm
- Left / Right: ☐ Wrist ☐ Hand ☐ Finger(s)
- Left / Right: ☐ Hip ☐ Thigh ☑ Knee ☐ Lower Leg
- Left / Right: ☐ Ankle ☐ Foot ☐ Toe(s)

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

Employee was walking outside to put some trash out and slipped and lost her balance. She fell to the ground and hurt her elbow and knee. The employee stated there was no obvious trip hazard or condition. Employee reported the incident and returned to her regular duties.

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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)

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? ☑ yes ☐ no
Specify where (shop floor, warehouse, client/customer site, parking lot, etc..): outside the back of the building

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ☑ no
If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ☐ yes ☑ no
If **yes,** provide name(s), position(s), and work phone number(s).
1. _____
2. _____

10. Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? ☐ yes ☑ no
If **yes,** please provide name and work phone number _____

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ☑ no
If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

D. Health Care

1. Did the worker receive health care for this injury? ☐ yes ☑ no
If **yes,** when: dd mm yy

2. When did the employer learn that the worker received health care? dd mm yy

3. Where was the worker treated for this injury? **(Please check all that apply)**
☐ On-site health care ☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ☐ 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 illness, this worker:**
☑ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
☐ **Has** lost time and/or earnings. **(Complete ALL remaining sections).**

Provide date worker first lost time: dd mm yy
Date worker returned to work (if known): dd mm yy ☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by:
☑ Myself ☐ Other Name Colette Shwetz
Telephone 807-622-1413 Ext. 7714

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ☐ yes ☑ no

2. Has modified work been discussed with this worker? ☐ yes ☑ no

3. Has modified work been offered to this worker? ☐ yes ☑ no
If **yes,** was it ☐ Accepted ☐ Declined
☐ 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
☐ Myself ☐ Other Name _____
Telephone Ext.

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

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Stone	Doreen	488733932

G. Base Wage/Employment Information - (Do not include overtime here)

1. Is this worker **(Please check all that apply)**

- [x] Permanent Full Time
- [ ] Permanent Part Time
- [ ] Temporary Full Time
- [ ] Temporary Part Time
- [ ] Casual/Irregular
- [ ] Seasonal
- [ ] Contract
- [ ] Student
- [ ] Unpaid/Trainee
- [ ] Other
- [ ] Registered Apprentice
- [ ] Optional Insurance
- [ ] Owner Operator or (Sub) Contractor

2. Regular rate of pay $ 29.67 per [x] hour [ ] day [ ] week [ ] other

H. Additional Wage Information

1. Net Claim Code or Amount — Federal: | Provincial:

2. Vacation pay - on each cheque? [ ] yes [x] no — Provide percentage: %

3. Date and hour last worked: dd mm yy: 27 10 20 — 5:00 [ ] AM [x] PM

4. Normal working hours on last day worked: From 9:00 [x] AM [ ] PM To 5:00 [ ] AM [x] PM

5. Actual earnings for last day worked: $

6. Normal earnings for last day worked: $

7. Advances on wages: Is the worker being paid while he/she recovers? [ ] yes [ ] no If yes, indicate: [ ] Full/Regular [ ] Other

8. Other Earnings (Not Regular Wages): Provide the **total of additional earnings** for each week for the 4 weeks before the accident/illness.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of accident/illness.

▼ Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..).

Period	From Date (dd/mm/yy)	To Date (dd/mm/yy)	Mandatory Overtime Pay	Voluntary Overtime Pay	Commission	Commission	Commission	Commission
Week 1			$	$	$	$	$	$
Week 2			$	$	$	$	$	$
Week 3			$	$	$	$	$	$
Week 4			$	$	$	$	$	$

I. Work Schedule (Complete either **A, B or C. Do not** include overtime shifts)

[ ] **(A.) Regular Schedule** - Indicate normal work days and hours.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	7	7	7	7	7	

▶ **Example:** Monday to Friday, 40 hours

S	M	T	W	T	F	S
	8	8	8	8	8	

or,

[ ] **(B.) Repeating Rotational Shift Worker** - Provide

NUMBER OF DAYS ON	NUMBER OF DAYS OFF	HOURS PER SHIFT(s)	NUMBER OF WEEKS IN CYCLE

▶ **Example:** 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle.

or,

[ ] **(C.) 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 1	Week 2	Week 3	Week 4
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	
Colette Shwetz	Human Resources Manager	
Signature	Telephone / Ext.	Date dd mm yy
	807-622-1413 / 7714	28 10 20

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

wsib ONTARIO | wsib.ca

7 Employer's Report of Injury/Disease (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

K. Additional Information

CINUP

COPY

August 11, 2022
CONFIDENTIAL

Doreen Stone
137 Reindeer Ave
Thunder Bay ON P7C 6A6

SCANNED

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.

Manulife

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. Class A

1 Plan sponsor statement

Plan sponsor name Nishnawbe Aski Legal Plan contract number

Billing division Account/Division number Plan member's certificate number

Do you want the waiting period added to the hire date? ○ Yes ○ No Permanent hire date (dd/mmm/yyyy) 01/Dec/99

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

Occupation Legal Aid Assessment officer Class Hours worked/week 35 Salary $48 215.60 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 Date (dd/mmm/yyyy) 10/Jan/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 DOREEN

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 ✓ No

3 Plan member address

Address (number, street, apt.) 511 McMaster Street

City Thunder Bay Province ON Postal code P7C5N1

4 For Quebec residents (age 65 or over)

Are you participating in the RAMQ drug plan? ○ Yes ✓ No

5 Application for coverage

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

I am applying for Extended Health Care for

- ○ Myself only
- ○ Myself and 1 dependant (child or spouse)
- ✓ Myself and 2 or more dependants (spouse and children)
- ○ None, because my spouse has coverage

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 Claim Secure

Insured's last name STONE First name KEVIN Date of birth (dd/mmm/yyyy) 25/05/1965

Effective date of coverage (dd/mmm/yyyy) Identification/certificate number 3711401056 Policy number 37114

Please indicate type of coverage under other plan:

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

Extended Health Benefits

- ○ Single
- ○ Couple
- ✓ Family
- ○ None

Dental Care

- ○ Single
- ○ Couple
- ✓ Family
- ○ None

Continued on the next page

7 Dependant information

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5 Application for coverage.

Spouse

Last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

Gender ○ Male ○ Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy)_____

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

**To apply for over-age disabled dependant coverage, please complete form GL0514E.

Last name	First name	Date of birth (dd/mmm/yyyy)	Gender Male	Gender Female	Over-age student	Over-age disabled dependant**
STONE	CAMERON	04/10/2001	✓	○	○	○
STONE	CARSON	24/05/2003	✓	○	○	○
			○	○	○	○
			○	○	○	○

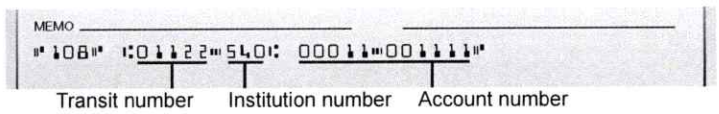
8 Direct deposit

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

Transit number 00507

Institution number 001

Bank account number 3105349



Electronic claim statement

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

Work email address stonedf@lao.on.ca Personal email address booksj@tbaytel.net

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 Helen Stone Date signed (dd/mmm/yyyy) Jan 18/18

10 Mailing instructions

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

Manulife

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/yyyy)
STONE DOREEN F	ON	14/01/1971

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)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
STONE KYLE N	03/04/1996	SON	33 %
STONE CAMERON B	04/10/2001	SON	33 %
STONE CARSON D	24/05/2003	SON	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.**

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.

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.**

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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(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

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

5 Trustee appointment

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

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

6 Declaration and authorization

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

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

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

I acknowledge that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.

Plan member signature	Date signed (dd/mmm/yyyy)
Doreen Stone	Jan 10/18

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 _____ First name _____ Date of birth (dd/mmm/yyyy) _____

Gender ○ Male ○ Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy)_____

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

**To apply for over-age disabled dependant coverage, please complete form GL0514E

Last name	First name	Date of birth (dd/mmm/yyyy)	Gender Male	Gender Female	Over-age student	Over-age disabled dependant**
STONE	CAMERON	04/10/2001	✓	○	○	○
STONE	CARSON	24/05/2003	✓	○	○	○
			○	○	○	○
			○	○	○	○

8 Direct deposit

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

Transit number 00507

Institution number 001

Bank account number 3105349

MEMO _____

⑈ 108 ⑈ ⑆00122⑆540⑆ 0001105 1111⑈

Transit number | Institution number | Account number

Electronic claim statement

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

Work email address stonedf@lao.on.ca Personal email address books@thbaytel.net

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 Helen Stone Date signed (dd/mmm/yyyy) Jan 18/18

10 Mailing instructions

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

Manulife

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

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1 Plan member information

Plan sponsor name: Nishnawbe-Aski Legal

Plan contract number:

Plan member certificate number:

Plan member name (last, first and middle initial): STONE DOREEN F

Province of residence: ON

Date of birth (dd/mmm/yyyy): 14/01/1971

2 Primary beneficiary

List all primary beneficiaries for Basic Life and/or Basic Accidental Death.

Percentages must total 100% to be valid.

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Plan member signature: Doreen Stone

Date signed (dd/mmm/yyyy): Jan 10/18