Manulife 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.

| 1 | Plan sponsor statement | Plan sponsor name Nishnawbe-Aski Legal Services Corporation Plan contract number 110020 | | | | | | | |
|-----|---|---|---------------------------|--|-------------------|-----------------|------------------------|-------------|----------------|
| | | Billing division | Account/Division | number | P | lan member's | certificate number | | |
| | | Do you want the waiting period | od added to the hire da | te? • Yes | ○ No | Permanent I | nire date (dd/mmm/ | уууу) | |
| | | Re-hire date (dd/mmm/yyyy) | | If a re-hir | e, date previo | us employmer | t ended (dd/mmm/) | ууу) | |
| | | Occupation | | | | | | | ually |
| a | certify that the plan r normal work schedule | nember listed below is active of at least the set minimum h | | | | The second | | | nember works |
| | | Plan administrator signature | | | | | | | |
| | | Is evidence of insurability red | quired? O Yes • | No (in o | order to deter | | | equired, pl | lease refer to |
| 2 | Plan member | If yes, please complete form | GL0004E and send to | Manulife for p | processing. | | | | |
| _ | information | Plan member's last name | SUGGAS | HIE | | _ First name | DARLE | ENE | |
| | To be completed by | Date of birth (dd/mmm/yyyy) | | | | | | | TYC |
| | employee | Language Kenglish | | | | | or civil union?) | | |
| 3 | Plan member address | Address (number, street, apt | | C. C | A CONTRACT OF THE | | | | |
| | 10000000 | City PKANGI | | | | | | BU- | - 21-0 |
| 4 | For Quebec re | sidents (age 65 or over) | Are you participati | ng in the RAM | O drug plan? | O Yes |) No | | |
| 5 | Application fo coverage | | certain benefits if the n | lan member h | as coverage | under their end | uso's plan If you w | ish to add | coverage at |
| | | I am applying for Extended I | | | | | ktended Dental Care | e for | |
| | | Myself only | | | THE RESERVE | Myself only | sterided Derital Carl | C 101 | |
| | | Myself and 1 dependan | t (child or spouse) | | | | ependant (child or s | spouse) | |
| | | Myself and 2 or more de | ependants (spouse and | (children) | | | r more dependants | | nd children) |
| | | None, because my spou | | | | | my spouse has co | | ind disidicity |
| | | Are you applying for Depend | ant Life? Yes | ○No Depe | endant Life ma | ay be mandato | ry. Refer to the polic | v details. | |
| 6 | Coordination | This section is required if you | | | | | | | |
| | of benefits | Do you or your dependants | spouse and/or children | n) have benefi | t coverage un | nder another be | enefits plan? OY | es XN | lo |
| | | If yes, please provide the fol | | | | | | | |
| In | sured's last name | | First name | | | Date | e of birth (dd/mmm/) | yyyy) | |
| Ef | fective date of covera | age (dd/mmm/yyyy) | Identification/d | certificate num | nber | | Policy n | | |
| Ple | ease indicate type of | coverage under other plan | Ext | ended Health | Benefits | | Dental Care | | |
| | | | 0 | Single | | | ○ Single | | |
| | cases where the info efault value will be ap | ormation is not complete a plied. | 0 | Couple | | | O Couple | | |
| | | | Ó | Family | | | Family | | |
| | | | 0 | None | | | O None | | |
| | | | | | | | | | |
| | | | | | | | | | |
| _ | | | | | | | | | |

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 Nishnawbe-Aski Legal Services Corporation | Plan contract number 110020 | Plan member certificate number | | | |
|---|--|---|--|---|--|--|--|
| | | Plan member name (last, first and middle initial) | Province of residence | Date of birth (dd/mmm/yyyy) | | | |
| _ | | Faries, Darlene Suggast | uic ON | 28/10/1982 | | | |
| 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 Basic Life and/or Basic Accidental Death | Suggashie I Kilyn Name of benediary (last, first and middle initially) | | Relationship to Jan member Percentage | | | |
| | Percentages must total 100% to be valid. | Name of beneficiary (last, first and middle mital) on | 2016 of 60 An | Relationship to plan member Percentage | | | |
| | Irrevocability | Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation. | In Quebec, the designation unles | uebec residents only of your spouse as beneficiary is irrevocable s otherwise specified. eneficiary, the designation is: table | | | |
| 3 | Optional coverage (if applicable) | Name of beneficiary (last, first and middle initial) | Date of birth (dd/mmm/yyyy) | Relationship to plan member Percentage | | | |
| | Plan contract number | Name of beneficiary (last, first and middle initial) | Date of birth (dd/mmm/yyyy) | Relationship to plan member Percentage % | | | |
| | List all beneficiaries for Optional Life and/or Optional Accidental Death. | Name of beneficiary (last, first and middle initial) | Date of birth (dd/mmm/yyyy) | Relationship to plan member Percentage % | | | |
| | Irrevocability | Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. You are responsible for ensuring the validity of your designation. | In Quebec, the designation unles | uebec residents only of your spouse as beneficiary is irrevocable s otherwise specified. peneficiary, the designation is: cable 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 | | | | | |
| | | Name of contingent beneficiary (last, first and middle initi | al) Date of birth (dd/mmm. | (yyyy) Relationship to plan member | | | |
| 5 | Trustee appointment | (DS) | | | | | |
| | Complete if any beneficiary named is under the age of majority. | any beneficiary under the age of majority (not applicable | in Quebec). | as Trustee to receive any amount due to | | | |
| 6 | Declaration and authorization | <u>I hereby</u> revoke any previous beneficiary designa 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 to us will be kept in a Group Life and Health Bene • our employees and service representatives ir • persons to whom you have granted access, a • persons authorized by law. | officerials access to your info the performance of their joined | rmation will be limited to: obs; | | | |
| | A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original. | You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information. | | | | | |
| | Alexander Marchael | Lacknowledge that more detailed information co discloses my personal information is available at plan sponsor. | ncerning how and why Mar www.manulife.ca/planmem | nulife Financial collects, uses and ber, or by requesting a copy from my | | | |
| | | Plan member signature N. Aur | | Date signed (dd/mmm/yyyy) 08/04/2021 | | | |

| information | in Section 5 Application | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| Spouse | Last name | First | name | | D | ate of birt | h (dd/mmn | n/yyyy) | |
| If there is not enough room to list your dependants, attach details on a separate | Gender OMale | Female If common law, | please prov | ide the effective | e date of col | nabitation | (dd/mmm | /уууу) | |
| | **To apply for over-age | disabled dependant coverage | e, please co | mplete form GI | L0514E. | | | | |
| sheet. Last name | First | name | Date of | Date of birth (dd/mmm/yyyy) | | Gender Male Female | | Over-age student | Over-age disabled dependant |
| Suggast | nie | Kilyn (5) Davion (5 | 1 | 1/10/ | 2003 | 0 | X | 0 | O |
| Suggest | 12 | Janina (5 | 12 | 105/ | 2005 | X | 0 | 0 | 0 |
| Juggus | | 000000000000000000000000000000000000000 | 7 | | | 0 | 0 | 0 | 0 |
| | | | | | 7 (10 7 10 7 10 7 10 7 | 0 | 0 | 0 | 0 |
| B Direct deposit | - 2 | 1027 | | | | | | | |
| Complete the following | | | Here. | | | | | ation of the | |
| section if you would ike to sign up for direct | Institution number | | 8* 1 | 081 1:0115 | 25401: <u>0</u> | 0011=0 | 01111 | | |
| deposit of your claim payments | Bank account number _ | 3975-498 | 7 | ransit number | Institution | number | Accoun | t number | |
| Electronic claim | By providing your email | address, you will receive an | invitation to | register for an | | | | | |
| statement | | Example 1 | | | | | | 100 DY | Limmer |
| | vvoik email address | | | reisonal emai | il address | qui (| | 3 | 011 |
| hereby apply for coverent an aspects of such rure and complete to the provided by me, and/oportion of this Coverage authorize Manulife to | and consent erage ("Coverage") under n Coverage may extend to the best of my knowledge, r my Dependants, in the fi the, and future claims there to collect, use, maintain an | the Group Benefits plan issue my spouse and eligible deperments of the properties of | ed to my pla endants (col blicant, it is n the best of c ninated as a on relevant t | in sponsor by Melectively, "Depe ny responsibility our knowledge, result of the pri to this application | Manulife Fina endants"). <u>Lo</u> y to ensure t <u>Lacknowle</u> : ovision of fal on ("Informa | incial ("Ma ertify tha hat any fu dge and a se, incom tion") for t | anulife"). L t the inforr orther verb agree that oplete, or n he purpos | understance mation in this real or written this Covera misleading in | that s form is statement ge or any formation. Benefits |
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| Lhereby apply for cove certain aspects of such true and complete to the provided by me, and/o portion of this Coverag Lauthorize Manulife to plan administration, au or organization with Interplan administrator, insteach other and with Montheir behalf as if the deductions from my pand administration, if not plan and any other finar Lunderstand and agreyment(s). Lalso unherein, and require my Manulife into the Acco | and consent erage ("Coverage") under n Coverage may extend to ne best of my knowledge, r my Dependants, in the file, and future claims there o collect, use, maintain an idit, assessment, investigation at the constitution, including any mater, investigative agency, anulife, its reinsurers and/ ery were signing it themselvely for my Group Benefits p ny SIN is used as my plan at I have identified on this notal institution I choose to ee that upon the deposit of derstand and agree that r personal written endorse | the Group Benefits plan issue my spouse and eligible deperments of the putture is true and complete to funder may be denied or termed disclose personal informatication, claim management, undedical and health profession, and any administrators of other its service providers, for the vest, and to disclose and receolan, if applicable. Lauthorize member certificate number, payments ("Payments") due to form. Lconfirm that this direct name in the future; and shall of any Payment(s) into the Ac Manulife may, at any time and ment relating to future Payment eled, either by contract or by I | ed to my plate and ants (collolicant, it is not the best of continuated as a non relevant if a derwriting ar als, facilities her benefits her benefits her benefits at the use of a lagree applacement, Manu dwithout print(s). I also | in sponsor by Nelectively, "Depeny responsibility our knowledge, result of the prior this application or providers, programs to contain the programs to contain the programs to contain the providers, programs to contain the programs to | Manulife Fina endants"). Logy to ensure to Lacknowle ovision of fallon ("Informating plan eligiprofessional rollect, use, med by my Doge Purposes. Trance Numbic ctronic version applies to di in writing by charged from ontinue the do owledge ani | ertify that any fudge and a se, incomition") for the billity ("Puregulatory aintain are pendants authorize ("SIN") on of this the finant of me, or many furth irrect dependent and agree the second and second agree the second agr | anulife"). L t the informather verb agree that uplete, or n he purpos rposes"). I bodies, a nd exchang to consei to consei to consei to my plan for the pui authorizat policy ("Po cial institut ny duly aut er liability to sit of Payi and any Pa | understance mation in this hal or written this Covera nisleading in es of Group ge this inform nt to this Aut n sponsor to rposes of ide ion is valid. blicy"), into th thorized repr with respect ment(s), as i | I that is form is statement ge or any formation. Benefits any person any group mation with horization make entification the bank amed by resentative, to such requested and by the statement of the such requested and by the statement is such requested. |
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Manulife Financial PO BOX 11006, STN CENTRE-VILLE MONTREAL QC H3C 4T8



Application for membership in a registered pension plan

Return to Great-West Life, Group Retirement Services

1-800-724-3402

| SECTION 1 - EMPLO | YER/PLAN SPONSOR | INFORMATION | | | | | |
|---------------------------------------|-------------------------------------|---|---------------------------------|--|--|----------------------------|--|
| Name of employer/plan | sponsor | | F | Policy/plan number | er | | |
| Nishna | | 68012 | | | | | |
| SECTION 2 - ISSUER | | | | | | | |
| The group annuity produ | uct for the registered pen | sion plan is issued by Lond | on Life Insura | ance Company (th | ne Issuer) 25 | 5 Dufferin | Avenue, London |
| West Life used under li | Life is a subsidiary of Gre | eat-West Life. The Great-W the promotion and marketi | est Life Assur | rance Company a | nd key desig | n are trad | e-marks of Great |
| SECTION 3 - APPLIC | CANT INFORMATION (| places print) | ng of msurant | ce products. | Contract Contract | True Services | |
| Last name | Middle initial | First name | | Division/subgr | oup Ident | ification/er | mployee number |
| SUGOASH | H M | DARLE | 118 | Division subgr | oop ident | moditions of | |
| Sulaca PSH Social insurance number | er (SIN) | Date of employment | Date of birth | | | Languag | ge |
| 1 authorize the use of my SIN | 68-983 | | 19821 | 0 28 | ☐ Male | Ø. | English |
| identification and record kee | N for tax reporting, | yyyy mm dd | | | Female | | French |
| Marital status: | Last name of s | pouse/partner First | name | Ema | l address | | |
| ☐ Married ☐ Comm | non law | | | Light Market | | | |
| Quebec civil union | | | | | | | |
| Single ☐ Other | | | | | | | email information |
| Address (apt. no., stree | et no., street) | | | about | he plan or serv | ces connec | ted with it |
| 38 h | 6 HOUSE RT | Po-Box | - 112 | | | | |
| City | CHICADE IS | Po-Box Provin | ce | No de la companya de | Postal c | ode | Short to per a se |
| Duran | | | | | | 40 FE 65 | |
| PKANGI | Kun | | NC | | Po | V-2 | LO |
| If the above address is | a PO hoy general delive | ery or rural route, also include | de the side of | -1 | Territoria de la constantina della constantina d | 105 | |
| Address (apt. no., stree | et no. street) | ry or rural route, also includ | City | street address be | Province | | Postal code |
| | | | City | | Flovince | | Postal code |
| Telephone no. | Alternate | telephone no. Provin | ice of employr | ment | Date joir | ned plan | |
| 807-713-5938 | | | | nem | Date joil | ned plan | |
| | | | VT. | | yy | yyy m | m dd |
| | ıs Indian) (minimum 10 d | 0 , | THE THE PERSON | | | 17 18 1 | The state of the s |
| is the applicant a confi | nected person? Yes* | No *Form T1007 noplicant is a connected pers | just be filed b | by the employer v | vith Canada | Revenue | Agency (the plan |
| | FICIARY INFORMATION | | on). | | | | |
| Primary beneficiary(ie | | | | | | | |
| | o, on my death | | | | | | |
| Last Name | First name | Date of birth yyyy mm | id | Relationship to | me | | % of benefit |
| SUGGASHIE | KILYN | 2002 | | DAUGH | TCP | | 750 |
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| | | | | | | | |
| | | | | | | | Total 100% |
| beneficiary(ies), the be | nefit will be paid to my es | primary beneficiaries prede imary beneficiary(ies), to n state. | ceases me, the ny contingent | eir share will be p beneficiary(ies) | aid to the sui named below | viving prir v. If there | mary beneficiaries is no contingen |
| Contingent beneficiar | y(les) on my death | | | | | | |
| Last Name | First name | Date of birth | | Delete de la constante de la c | | | |
| | Record and Department of the second | yyyy mm o | bi | Relationship to | me | | % of benefit |
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| | | | | | | | Total 1000 |
| | | 4 | | | | | Total 100% |

Application for membership in a registered pension plan (continued) SECTION 4 - BENEFICIARY INFORMATION (continued) Contingent beneficiary(ies) on my death (continued) These designations are for all benefits payable under the plan unless pension legislation or the terms of the plan require payment to my spouse or common-law partner All beneficiary designations are revocable except: where a Designation of irrevocable beneficiary form is completed Where Quebec law applies:

where Quebec law applies and I have designated my married or civil union spouse as my beneficiary - the box below applies.

If I designate my married or civil union spouse as my beneficiary, they will be irrevocable unless I check the box below. If not, restrictions will apply, unless I obtain the consent of my spouse. For example, I will be prevented from changing my beneficiary, making withdrawals (where permitted) or exercising certain other rights.

I designate my married or civil union spouse as my revocable beneficiary.

Where a minor beneficiary or a person who lacks legal capacity resides in Quebec - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks capacity, will be paid to their tutor(s) or curator, unless a valid trust has been established for the benefit of the beneficiary, by will or by separate contract, to receive any such payment and the Issuer has been provided notice of the trust. If a trust has already been established, designate the trust as the beneficiary in this section. Before designating a trust, legal advice should be sought.

| SECTION 5 - | TRUSTEE | APPOINT | MENT |
|-------------|---------|----------------|------|

| If a formal trust does not exist, I hereby appoint: | otherwise lack regar capacity AND DO NOT IN | LOIDE III G |
|---|---|----------------------------------|
| Full name of trustee being appointed (last name, then first) | Trustee for (indicate beneficiary name) | Relationship of trustee to me |
| Juggashie/Turtle Gloria Suppo | KILYN SUGBASHIE | Sister |
| (DS) (DS) | DAVION SUGLASHIE | |

as trustee to receive, in trust, all benefits payable to any beneficiary designated under the plan who, at the time benefits are paid, is a minor or lacks legal capacity to give a valid discharge according to the laws of the beneficiary's domicile. Payment of benefits to the trustee discharges the Issuer to the extent of the payment. I authorize the trustee in their sole discretion to use the benefits for the education or maintenance of the beneficiary and to exercise any right of the beneficiary under the plan. The trustee may, in addition to the investments authorized for trustees, invest in any product of, or offered by the Issuer or its affiliated financial institutions. The trust for any beneficiary will terminate once that beneficiary is both of age of majority and has legal capacity to give a valid discharge. I direct the trustee to deliver at that time to the beneficiary the assets held in trust for that beneficiary. For my personal representative may by writing appoint a new trustee to replace the former trustee

SECTION 6 - PAYROLL DEDUCTION AUTHORIZATION

I authorize my employer to deduct the following from each pay

 member required contributions under the provisions of the plan; and.

 if permitted by the plan, additional voluntary contributions of I reserve the right to alter or discontinue this option.

SECTION 7 - INVESTMENT SELECTION

Select investment(s) if the plan sponsor/plan administrator has given members the right to select investments for all or part of the contributions to the plan. If a selection is not made, contributions will be invested in the default investment.

| Name of investment and/or code | Percentage | Name of investment and/or code | Percentage |
|--------------------------------|------------|--------------------------------|------------|
| advanced cont | % | | % |
| Continuium fund | 100 % | | % |
| 201711110011 | % | | % |

Total allocation must equal 100%

SECTION 8 - CONFIDENTIAL INFORMATION FILE

The Issuer will establish a confidential information file that contains personal information concerning the applicant. By submitting a written request to the Issuer, the applicant may exercise rights of access to, and rectification of, the file. The Issuer will collect, use and disclose the applicant's personal information to: process this application and provide, administer and service the plan applied for (including service quality assessments by or on behalf of the Issuer); advise the applicant of products and services to help the applicant plan for financial security; investigate, if required, and pay benefits under the plan, create and maintain records concerning our relationship as appropriate; and, fulfil such other purposes as are directly related to the preceding. The Issuer may use service providers within or outside Canada. Personal information concerning the applicant will only be available to the applicant, plan sponsor, plan administrator, pension and related government authorities, the Issuer, its affiliates, and any duly authorized employees, agents and representatives of the Issuer or its affiliates, within or outside Canada, for or related to the purpose of the plan, except as otherwise may be required, authorized or allowed by law or legal process, or by the applicant. In all cases, availability is subject to lawful determination by the Issuer. Personal information is collected, used, disclosed, or otherwise processed or handled in accordance with governing law, including applicable privacy legislation, and the applicant's personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. For more information about our privacy practices, please ask for a copy of our Privacy Guidelines brochure.

SECTION 9 - SIGNATURE

I confirm the information on this form and will update it in the future as it changes. I am aware of the reasons the information covered by my authorizations and consents is needed, and the benefits of, and the risks of not, authorizing/consenting. I authorize and consent to the Issuer collecting, using, and disclosing personal information concerning me for the purposes outlined in the Confidential Information File section. This authorization and consent is given in accordance with applicable law and without limiting the authorizations and consents given elsewhere in this application. My authorizations and consents will begin the date this application is signed and end when no longer required. My authorizations and consents may be revoked at any time by either written or electronic notification to the Issuer, subject to legal and contractual considerations. A reproduction of my authorizations and consents will be as valid as the original

| Signature | OI | applicant | |
|-----------|----|-----------|--|
| | | 10 | |

April. 08/21

RPP (Pay) - June 2017

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