Manulife

B

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 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) 04/JAN/10

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

Occupation community legal worker Class B Hours worked/week 35 Salary $ 42,404 Frequency A

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) 07/DEC/2017

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

To be completed by employee

Plan member's last name Wesley First name Roberta

Date of birth (dd/mmm/yyyy) 4/12/69 Gender ○ Male ● Female Province of residence ON

Language ● English ○ French Do you have a spouse? (married, common law or civil union?) ○ Yes ○ No

3 Plan member address

Address (number, street, apt.) 19 Nabakhabo St BOX 227

City Constance Lake Province ON Postal code P0L1B0

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 _____

Insured's last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

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

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

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

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)_____

**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**
Mendowegan Wesley J	Deidre Tanner	24/11/96	○	●	○	○
		15/02/06	●	○	○	○
			○	○	○	○
			○	○	○	○

8 Direct deposit

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

Transit number _____

Institution number _____

Bank account number _____

MEMO _____

⑈108⑈ ⑆01122⑈540⑆ 0001100011111⑈

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 rwesleye@nanlegal.on.ca Personal email address roberta.wesleye@hotmail.com

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 _____ Date signed (dd/mmm/yyyy) 6/12/17

10 Mailing instructions

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

THE Great-West Life ASSURANCE COMPANY

APPLICATION FOR GROUP COVERAGE

For GWL Head Office Use Only
GWL Certificate Number

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 7 are to be completed by the plan member.

1. Plan Sponsor Section

This section is to be completed by the plan administrator.

Please note the policy waiting period will be applied to the eligible date of employment.

Plan number: 106790 Division number: 1 Benefit class: 2

Plan sponsor: NISHNAWBE-ASKI LEGAL SERVICES CORP.

Plan member ID: _____ Cost centre (if applicable): _____

Date of full time employment: Month JAN Day 04 Year 2010 2010

Occupation: TALKING TOGETHER FACILITATOR Earnings: $ 38,000.00 per ☒ year ☐ month ☐ week ☐ hour

Plan member province of residence: ONT Plan member province of employment: ONT.

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

Plan member name (print): Wesley (last name) Roberta (first name) Carol (middle initial)

Gender: ☐ Male ☑ Female Date of birth: Month 12 Day 4 Year 69

Plan member mailing address:

Street address: 19 Nabahkabo

City: Calstock Province: ON Postal code: P0L1B0

Do you have a spouse (married, common-law or civil union spouse)? ☐ Yes ☑ No

Do you have dependant children, including full time students or disabled adults? ☑ Yes ☐ No

How many dependants in total, including spouse? 4

3. Refusal of Benefits

This section is to be completed by the plan member.

Cross outs and/or corrections in this section must be initialed.

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but I **decline** to participate in:

Healthcare for ☐ myself and my dependants ☐ my dependants only

Dentalcare for ☐ myself and my dependants ☐ my dependants only

Spousal insurer's name: _____ Plan number: _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependants may be required to provide proof of insurability acceptable to Great-West Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. Beneficiary Designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original of this form will be required for a life claim.

Crossed out or corrected beneficiary designations must be initialed.

Please print clearly, in INK.

Beneficiary Designation

Beneficiary's name(s) last name	first name	middle initial	Percent allocated	Date of birth month/day/year	Relationship to plan member
Mendowegan	Darwin	C P	30%	01/13/91	Son
Mendowegan	Deidre	N D	30%	11/24/96	Daughter
Wesley	Tanner	J P	40%	02/15/06	Son

To be divided as follows: ☒ As per the percentages indicated above, or ☐ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable", below.

I hereby make the above beneficiary designation:

☐ **Revocable**, I may change this beneficiary designation at any time

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

CONTINUE ON REVERSE SIDE

To be completed by the plan administrator

Plan number: 106790 Plan member name: Roberta Wesley Plan member ID: _____

5. Dependant Information

This section is to be completed by the plan member.
Complete this section if the plan includes health and/or dental coverage and you have not refused such coverage for your dependants in section 3.
If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Spouse Information

last name | first name | middle initial

Date of birth (month/day/year)

Gender: Male ☐ Female ☐

What group benefits coverage does your spouse have through his/her employer?

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Dependant Information

last name	first name	middle initial	Date of birth month/day/year	Gender Male	Gender Female	Full time student Yes	Disabled dependant Yes
Mendowegan	Darwin	CP	01/13/91	☑	☐	☑	☐
Mendowegan	Deidre	ND	11/24/96	☐	☑	☑	☐
Wesley	Tanner	JP	02/15/06	☑	☐	☐	☐
Wesley	Curran	AT	04/19/95	☑	☐	☑	☐

6. Privacy

This section explains Great-West Life's commitment to privacy.

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to determine your eligibility for coverage, and to administer the plan, including investigating and assessing claims, and creating and maintaining records concerning our relationship.

7. Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

Authorizations and Declarations

I hereby apply for coverage under the group benefits plan issued by Great-West Life.

I authorize:

- my plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable;
- Great-West Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: R. Wesley Date: Jan. 4/10