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 Plan contract number 0110020

Billing division A 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) 5/Nov/2018

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

Occupation CRRW Class _____ Hours worked/week _____ Salary $_____ Frequency _____

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) 20/2/19

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 SUTHERLAND First name DAVID

Date of birth (dd/mmm/yyyy) 07/03/1951 Gender ⊘ Male ○ Female Province of residence ONTARIO

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

3 Plan member address

Address (number, street, apt.) 15 Riverside Road

City Fort Albany Province ONT Postal code P0L 1H0

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

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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**
			◯	◯	◯	◯
			◯	◯	◯	◯
			◯	◯	◯	◯
			◯	◯	◯	◯

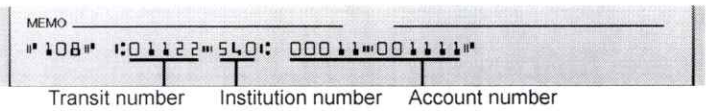
8 Direct deposit

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 _____



Electronic claim statement

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

Work email address _____ Personal email address _____

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) 09/NOV/2018

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)

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
SUTHERLAND	01/MAL/1986	DAUGHTER	100 %
			%
			%

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.**

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
◯ Revocable ◯ Irrevocable

4 Contingent beneficiary

You may wish to designate a contingent beneficiary(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
SUTHERLAND C	29/FEB/2008	GRANDSON

5 Trustee appointment

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

I appoint _____ 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)
	09/NOV/2018.