Manulife Financial

Group Benefits
Application for Optional Life Insurance for Plan Member and Spouse

INSTRUCTIONS - Please print all answers

Complete this **Application for Optional Life** form and return to your plan administrator **no later than** 31/Oct/2011.

In addition to enrolling for the $50,000 coverage level that is available to you without evidence of insurability, you may wish to consider applying for a higher amount, and/or applying for optional life coverage for your spouse. If you wish to do so, please:

- complete this **Application for Optional Life** and return it to your plan administrator by the date noted above.
- complete GL0004E, ***Evidence of Insurability*** for yourself (if applying for more than $50,000) and your spouse (for any amount of coverage.)
- mail a photocopy of this Application for Optional Life form together with the original evidence of insurability form to the address shown on the evidence of insurability form.

1 Plan information

Plan contract number(s)	Division number	**Units of**	**Benefit maximum**
39949		10,000	$ 250,000.00

2 Plan member's information

Plan member's name (last, first and middle initial)	Plan member certificate number	Date of birth (dd/mmm/yyyy)

Language preference/Langue préférée ◯ English/Anglais ◯ French/Français

Sex ◯ Male ◯ Female

Province of residence

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

3 Coverage requested

Refer to units and benefit maximum indicated in section 1 when selecting coverage amounts.

*Evidence of insurability required for all spousal amounts and for employee amounts in excess of $50,000.

Employee optional amount:

Present amount of optional life	$
Amount of coverage requested without evidence of insurability (maximum of $50,000 combined with present amount)	$
Additional amount applied for *	$
Total amount	$

Spousal optional amount:

Spouse's present amount of optional life	$
Additional amount applied for *	$
Total amount	$

4 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

Name of beneficiary (last, first and middle initial)	Relationship to plan member
Additional name, if applicable (last, first and middle initial)	Relationship to plan member
Additional name, if applicable (last, first and middle initial)	Relationship to plan member

Complete if the beneficiary 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).

Irrevocability

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

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.**

Please complete both pages of this form.

5 Spousal coverage

Note: you will be the beneficiary of your spouse's insurance, if you are then living, otherwise the beneficiary will be your estate.

Spouse's name (last, first and middle initial)	Sex	Date of birth (dd/mmm/yyyy)
	◯ Male ◯ Female	

Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

6 Plan member's information

Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **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 understand** that any Coverage shall not become effective until approved by Manulife. **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. **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/groupbenefits, or from my Plan Sponsor.

Plan member's signature	Date (dd/mmm/yyyy)

Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date (dd/mmm/yyyy)

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 your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

7 Mailing instructions

Please send the completed form to your plan administrator.

Plan administrator's name and address