

FollowMe™ Health Application Form



AIR MILES® Collector #: 8 | | | | | | | | | | | | | | | |

For Manulife Financial Use Only
Keyed _____
Approved _____

Logo ID: ON2169
Agent ID: _____

Please print in ink

Part A — General Information

Primary Applicant's Last Name _____ First Name _____ Initial ____ Address _____ City _____ Province _____ Postal Code _____ Telephone (Res.) (____) _____ Telephone (Bus.) (____) _____ If additional information is required, how may we contact you? <input type="checkbox"/> Home Telephone <input type="checkbox"/> Office Telephone Date of Birth <u>DD / MM / YYYY</u> Age ____ <input type="checkbox"/> Male <input type="checkbox"/> Female Health Card No. _____ Please provide us with information about your current or recently ended group health plan: Employer Name _____ Insurance Company _____ Date Benefits Ended <u>DD / MM / YYYY</u> Group and Identification Numbers _____	Co-Applicant's Last Name _____ First Name _____ Initial ____ Address (if different than that of Primary Applicant) _____ City _____ Province _____ Postal Code _____ Telephone (Res.) (____) _____ Telephone (Bus.) (____) _____ If additional information is required, how may we contact you? <input type="checkbox"/> Home Telephone <input type="checkbox"/> Office Telephone Date of Birth <u>DD / MM / YYYY</u> Age ____ <input type="checkbox"/> Male <input type="checkbox"/> Female Health Card No. _____ Please provide us with information about your current or recently ended group health plan (if different than that of Primary Applicant): Employer Name _____ Insurance Company _____ Date Benefits Ended <u>DD / MM / YYYY</u> Group and Identification Numbers _____
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Part B — Dependants to be Covered

Last Name	First Name	Health Card No.	Code	Sex	Birth Date DD/MM/YYYY	Age
D E P E N D A N T			02			
D E P E N D A N T			02			
D E P E N D A N T			02			

Part C — Plan Choice

I/We apply for FollowMe Health: Basic Enhanced Enhanced Plus Premiere

Part D — Beneficiary Designation

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Primary Applicant's Beneficiary Last Name _____ First Name _____ Relationship to Primary Applicant _____ If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed, except in Quebec where benefits will be paid directly to the tutor or administrator of the beneficiary and no trustee may be appointed. Trustee: Last Name _____ First Name _____ Relationship to Primary Applicant _____	Co-Applicant's Beneficiary Last Name _____ First Name _____ Relationship to Co-Applicant _____ Trustee: Last Name _____ First Name _____ Relationship to Co-Applicant _____
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For Quebec residents only:
 In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)
 I hereby declare and stipulate that the beneficiary designation made in this form is revocable. I hereby declare and stipulate that the beneficiary designation made in this form is irrevocable.



Part E — Payment Options

INITIAL PAYMENT: I hereby authorize Manulife Financial to debit the initial 2 months premium, \$ _____ from my/our:

Option #1 Financial Services Account (Pre-Authorized Collection) Option #2 Credit Card Account

SUBSEQUENT PAYMENTS

will be made by: Option #1 Pre-Authorized Collection (PAC) plan from my Financial Services Account
PAC Billing Frequency: Monthly Semi-Annually (2% discount) Annually (4% discount)

Important: Please enclose a sample cheque marked "VOID".

Option #2 Credit Card Account
Credit Card Billing Frequency: Monthly Semi-Annually Annually

Please note: billing frequency discounts are not available for Credit Card payment options.

Option #3 Direct Billing
Direct Billing Frequency: Semi-Annually (2% discount) Annually (4% discount)

Part F — Payment Information and Authorization

For Pre-Authorized Collection (PAC) Options

Name of Account holder _____
(if other than Applicant)

Financial Institution _____

Type of Account: Chequing Non-Chequing

Joint Accounts: Is this a joint account requiring only one signature? Yes No

If more than one signature is required on withdrawals issued against the account, both account holders must sign the authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payment from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

For Credit Card Payment Options

Credit Card: Visa MasterCard Amex

Account Number: _____ Expiry Date: _____ MM / YY

Name of Account holder _____
(if other than Applicant)

Payment Authorization

For Pre-Authorized Collection and Credit Card billing options – I/we hereby authorize Manulife Financial to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This Authorization may be terminated by either Manulife Financial or by me/us through written notice. Manulife Financial may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A \$25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Signature of Cardholder or Account holder

Second signature if joint account

Part G — Declaration

ALL APPLICANTS MUST COMPLETE THIS SECTION

This plan is underwritten by The Manufacturers Life Insurance Company.

Check here if you do not wish to receive further information and material on Manulife Financial products.

I/we hereby acknowledge that the statements contained herein are true and complete and together with any other forms signed by me/us in connection with this application form the basis for any Policy issued hereunder. I/we acknowledge receipt of and agree with the Notice on Privacy and Confidentiality and Notice on Information provided to the AIR MILES® Reward Program. I/we understand and agree that coverage shall not become effective until the first of the month following final approval.

I hereby designate the individual(s) named as beneficiary(ies) to receive any Accidental Death and Dismemberment proceeds payable.

A photocopy of this signed authorization shall be as valid as the original.

Signature of Applicant

Signature of Co-Applicant

DD / MM / YYYY

Date