Manulife Financial

For your future™

Group Benefits – *e*-Application for Change

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

1 General information

We require this information to process your request.

Plan contract number(s)	Plan member certificate number	Plan sponsor
633399		Mohawk Canada Corporation

Plan administrator name	Plan administrator telephone number Ext.

Plan member name (last, first, middle initial)

To be completed and signed by plan sponsor.

I certify that the **plan member** listed above 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 signed (dd/mmm/yyyy)

2 Plan member name change

New name (last, first, middle initial)

3 Plan member address

Address (number, street, apt. number)

City	Province	Postal code

4 Addition of benefits

A spouse/common law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.

Addition of Extended Health Care I wish to ADD Extended Health Care for	**Addition of Dental Care** I wish to ADD Dental Care for
◯ Myself ONLY	◯ Myself ONLY
◯ Myself AND 1 dependant	◯ Myself AND 1 dependant
◯ Myself and 2 or more dependants	◯ Myself and 2 or more dependants
◯ My dependants ONLY (I am already covered)	◯ My dependants ONLY (I am already covered)

Dependent Life ◯ I wish to add Dependent Life Insurance

Reason for additions (check one only)

*Please enter the date that the common-law cohabitation began in the "Date commenced" field.

◯ Marriage	◯ Common-law relationship*	◯ Spouse's coverage cancelled
Date of marriage (dd/mmm/yyyy)	Date commenced (dd/mmm/yyyy)	Cancellation date (dd/mmm/yyyy)

◯ Other — Please give details of "Other". If necessary, attach a separate sheet.

Effective date (dd/mmm/yyyy)

In order to determine if evidence of insurability is required, please refer to your contract.

Is evidence of insurability required? ◯ Yes ◯ No

If evidence of insurability is required, plan members must complete GL0004E, *Evidence of Insurability*, and send it to Manulife Financial for processing. **Manulife Financial will not contact your Plan Administrator to verify that this form has been mailed.**

5 Refusal of benefits

You may refuse Extended Health Care and or Dental Care for yourself and/or your dependant(s) only if covered for similar benefits under spouse's plan.

Refusal of Extended Health Care I do **NOT** want Extended Health Care for	**Refusal of Dental Care** I do **NOT** want Dental Care for
◯ Myself ONLY	◯ Myself ONLY
◯ Myself and my dependant(s)	◯ Myself and my dependant(s)
◯ My dependant(s) ONLY	◯ My dependant(s) ONLY
Date of refusal (dd/mmm/yyyy)	Date of refusal (dd/mmm/yyyy)

If you wish to add coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

6 Termination of dependent coverage

◯ I wish to terminate coverage for a specific dependant(s) (see section 9)

◯ I wish to terminate ALL coverages for ALL dependants

◯ Please change coverage to single

Effective date of termination (dd/mmm/yyyy)

Reason for termination

7 For Quebec residents (age 65 or over)

◯ I am participating in the RAMQ drug plan provided by the Quebec government

◯ I am NOT participating in the RAMQ drug plan provided by the Quebec government

8 Co-ordination of benefits

This information is important for the correct adjudication of your claims.

Complete sections 8 and 9 only if you are required to enrol your spouse and children, and you need to change information.

Spousal Health Coverage	Does your spouse have health coverage under his/her own insurance plan?	◯ Yes ◯ No	Effective date (dd/mmm/yyyy)
Spousal Dental Coverage	Does your spouse have dental coverage under his/her own insurance plan?	◯ Yes ◯ No	Effective date (dd/mmm/yyyy)

Does your spouse's health/dental plan cover:

Health	Dental	
◯	◯	Your spouse only
◯	◯	Your spouse and yourself only
◯	◯	Your spouse and children only
◯	◯	Your spouse, you and your children

Spouse's date of birth (dd/mmm/yyyy)

9 Family information

Complete this section only when you are changing information pertaining to dependants that have previously been enrolled OR when you are adding/deleting a dependant. If more than 4 children, please attach a separate listing.

Change type code A/D/C (see below)	**Effective date of change** (dd/mmm/yyyy)	**Spouse/child name** (last, first, middle initial)	**Date of birth** (dd/mmm/yyyy)	**Sex** (M or F)	Relationship code H/W/S/C (see below)	**Full-time student?** (Yes or No)
		spouse		◯ M ◯ F		N/A
		child		◯ M ◯ F		◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No

Change type codes: **A** = Add, **C** = Change, **D** = Delete **Relationship codes:** **H** = Husband, **W** = Wife, **S** = Common-law spouse, **C** = Child

If a dependant is disabled and over-age, please complete GL0514E, *Application for Over-Age Disabled Dependant Coverage*.
If a dependant is an over-age student, please complete GL4408E, *Request for Termination of Over-age Student Dependant*.

10 Beneficiary designation

Should you wish to change you beneficiary designation, please complete and sign GL1435E, *Beneficiary Designation*.

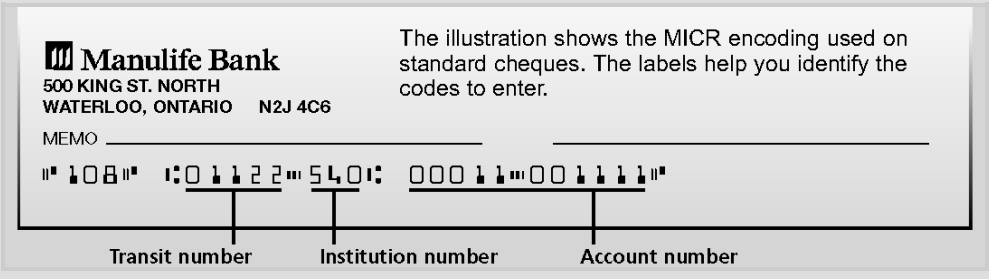
11a Direct deposit

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

Name of financial institution

Address (number, street)	City	Province	Postal code

Transit number (5 digits)	Institution number	Bank account number



11b Electronic claim statement

By completing the email section, you will be sent an invitation to register for an online member account.

Complete the following section only if your plan offers online services and you wish to enrol for the service.

If the email and banking fields are completed you will receive an electronic claim statement, otherwise you will receive your claim statement by mail.

Email

12 Plan member signature

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/groupbenefits, or from my Plan Sponsor.

Print

Please sign and date here.

Plan member's signature

Date signed (dd/mmm/yyyy)

13 Mailing instructions

Please send the completed form to:

Plan Member Administration
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1

La version française du document se trouve à l'adresse www.manuvie.ca/assurancecollective