Manulife

CDSPI ADVICE. INSURANCE. INVESTMENTS.

FollowMe™ Health

FollowMe™ Health Application

All applicants must complete parts A, B, C, D, E and F.
All applicants must complete and sign the Applicant's Declaration.

F84

Advisor ID: CDSPI01

Please print in ink.

Part A • General Information

Does each applicant have provincial/territorial health care coverage?* ❑ Yes ❑ No
* All applicants must have coverage under a provincial/territorial health care insurance plan in order to be eligible for this insurance product.
If anyone on the application does not meet this requirement, please contact our Customer Service for more information

Primary Applicant:

Last Name _____ First Name (Dr.) _____ Initial _____

Address _____ City or Town _____

Province _____ Postal Code _____ Email _____

Home Telephone ( ) _____ Office Telephone ( ) _____

If additional information is required, how may we contact you? ❑ Home ❑ Office ❑ Email Best time to call _____ AM ❑ PM ❑

Date of Birth _____ (DD/MM/YYYY) Age _____ ❑ Male ❑ Female

Are you retired from the active practice of dentistry (please check one): ❑ Yes ❑ No

Please provide us with information about your current or recently ended health plan:

Employer Name (if applicable) _____ Insurance Company _____

Date Benefits Ended _____ (DD/MM/YYYY) Group Policy and Identification Numbers _____

Co-Applicant:

Last Name _____ First Name _____ Initial _____

Home Telephone ( ) _____ Office Telephone ( ) _____

If additional information is required, how may we contact you? ❑ Home ❑ Office ❑ Email Best time to call _____ AM ❑ PM ❑

Date of Birth _____ (DD/MM/YYYY) Age _____ ❑ Male ❑ Female

Part B • Dependants To Be Covered

FIRST NAME	LAST NAME	CODE	SEX	BIRTH DATE DD MM YYYY	AGE
		02			
		02			
		02			

Part C • Plan Choice

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

Part D • Beneficiary Designation

I/We hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for.
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 _____

Percentage of Benefit _____

Co-Applicant's Beneficiary

Last Name _____

First Name _____

Relationship to Co-Applicant _____

Percentage of Benefit _____

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee unless a Trustee is appointed.
By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the Trustee to hold in trust for the child until the child comes of age.

Trustee:

Last Name _____

First Name _____

Relationship to Beneficiary _____

Trustee:

Last Name _____

First Name _____

Relationship to Beneficiary _____

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Part E • Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, $ _____ , from my/our:

Option #1 ❑ Financial Services Account (Pre-Authorized Debit)

Option #2 ❑ Credit Card Account

IMPORTANT: Initial Payment will be taken on the **day approved** (not the effective date). Future payments will be taken on the first of each month.

Subsequent Payments will be made by:

Option #1 ❑ Pre-Authorized Debit (PAD) from my/our financial services account

PAD Billing Frequency: ❑ Monthly ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

Important: For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part F.

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.
Please complete Part F.

Option #3 ❑ Direct Billing

Direct Billing Frequency: ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

Part F • Payment Information and Authorization

Credit Card Option Payment Information & Payment Authorization

I/We hereby authorize Manulife 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 or by me/us through written notice. Manulife 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.

Credit Card: ❑ Visa ❑ MasterCard ❑ American Express

Card Number _____ Expiry Date _____ (MM/YYYY)

Name of Cardholder _____ Signature of Cardholder _____

Second Signature if Joint Account _____ Dated _____ (DD/MM/YYYY)

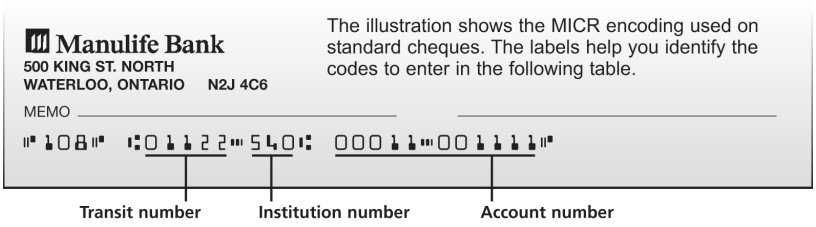
Pre-Authorized Debit (PAD) Payment Information & Payment Authorization

Please use the following banking information:

❑ From the cheque used to make the first payment

OR

❑ As follows:
(only complete the table below if you do not have a void cheque)



The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.

Transit Number _____ Institution Number _____ Bank Account Number _____

Financial Institution _____ Address _____

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 this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments 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.

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We or Manulife may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-268-3763, or more_info@manulife.com or write to us at Manulife, P.O. Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, contact your financial institution or visit www.payments.ca.

Name of Account Holder _____

Signature of Cardholder _____ Dated _____ (DD/MM/YYYY)

Second Signature if Joint Account _____ Dated _____ (DD/MM/YYYY)

Account Holder Address (if different from Applicant) _____

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used for insurance purposes, such as but not limited to processing this application, and any subsequent claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Certain basic enrolment information will be shared with the Plan Sponsor, CDSPI, but no identifiable claims information will be shared. Please consult CDSPI's Privacy Policy for further information on how CDSPI collects and uses your personal information.

Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6.

Applicant's Declaration and Authorization • All Applicants Must Complete This Section

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 Manulife's Notice on Privacy and Confidentiality outlined above. I/We understand and agree that coverage shall not become effective until the first of the month following final approval.

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

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

		(DD/MM/YYYY)
Signature of Primary Applicant	Signed at (City, Province)	Dated
Signature of Co-Applicant	Signed at (City, Province)	(DD/MM/YYYY) Dated

Please send the completed application to:

For Regular Mail:
Manulife
P.O. Box 670
Stn Waterloo
Waterloo, Ontario N2J 4B8

For Courier:
Manulife
500 King Street
Consumer Markets, New Business
Del. Stn 500-GB
Waterloo, Ontario N2J 4C6

Manulife

FollowMe™ Health is offered through The Manufacturers Life Insurance Company (Manulife).

Accessible formats and communication supports are available upon request. Visit **cdspi.com/accessibility** for more information.

CDSPI-FM-APP.05/18
180165

Plan underwritten by The Manufacturers Life Insurance Company (Manulife).