

# enrollment and eligibility

At the time the plan member is hired, he/she will be asked to complete and sign the ENROLLMENT form **B3485E** even though he/she may not yet be eligible. By doing this when the plan member is hired, you ensure that each individual has the opportunity to join the plan, and that no one will be overlooked in error. If you prefer to have this form in electronic format, please contact your group representative. The form is also available on the website.

**Note:** A plan member becomes covered after they have completed the eligibility or waiting period. To determine eligibility, please refer to your group policy contract.

## Plan Member Enrollment

The first section of the enrollment form contains specific information regarding the plan member and is to be completed by the Plan Administrator. The remainder of the form is completed by the plan member. All appropriate information should be entered on the form. The plan member should specify the named beneficiary and sign where indicated.

## Dependent Information

This section needs to be completed if you have chosen to have plan member/dependent eligibility certification done by Manulife. If you have chosen full family certification, it is important to collect the coordination of benefits information so that claims can be assessed according to the rules of coordination of benefits. This section may also be useful even if you choose to do your own plan member certification.

## Refusal of Benefits

For **contributory** coverage, where the plan member chooses not to apply for coverage, this section of the form must be completed with the appropriate reason indicated.

**Note:** A plan member cannot choose to be covered for a particular **contributory** benefit; he/she must be insured for all **contributory** benefits or none, except for Flex Benefit Programs and as follows.

When coverage for health or dental insurance is provided under this plan on a **contributory** basis and the plan member or the plan member's spouse and children have the same coverage under the spouse's plan, the plan member may choose not to apply for these coverages. The plan member should indicate which coverage he/she is refusing.

The employee must sign and date this section.

For **non-contributory** coverage, all plan members and dependents must be covered.

## Change(s) of Beneficiary

Should the plan member wish to change the designated beneficiary at a later date, he/she may do so at any time by completing one of the change sections. Please ensure that the plan member signs and dates the change.

## Change of Plan Member Name

The next section of the form is to be used only when there is a change in the plan member's name (e.g. marriage). The new name and date of change should be entered and the reason indicated.

## SECTION 1 - TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Plan Sponsor - Name	Policy #	Division
Plan Member - Last Name	First Name and Initial	ID #/S.I.N.
Plan Member - Province of Residency	Life Class	Health Class
		Gender
Employment Start Date (yyyy/mm/dd)	Position Title	Annual Salary \$
		Insured Date (yyyy/mm/dd)

## SECTION 2 - TO BE COMPLETED BY THE PLAN MEMBER

### GROUP HEALTH AND DENTAL INSURANCE

#### A) Election of Benefits

##### Health Options

- E  **Employee Only:** I do not wish to cover any dependents (spouse or children)
- P  **Plus One:** I wish to cover one dependent (spouse or child)
- F  **Family:** I wish to cover my dependents (spouse and/or child)

##### Dental Options

- E  **Employee Only:** I do not wish to cover any dependents (spouse or children)
- P  **Plus One:** I wish to cover one dependent (spouse or child)
- F  **Family:** I wish to cover my dependents (spouse and/or child)

#### B) Waiver of Benefits: My benefits have been explained by my Contractholder/Employer and I elect to waive:

Waiver: My healthcare benefits for:

- my dependents
- myself and my dependents

Waiver: My Dental care benefits for:

- my dependents
- myself and my dependents

I and/or my dependents are presently covered with regard to the above benefits under my spouse's plan as indicated below.

Name of Spouse's Employer	Name of Insurance Company	Policy No.
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Type of Life Coverage Required  Employee Only  Employee and Family

Do you wish to apply for Optional Life Insurance for you or your spouse? (if provided)  Yes  No

If yes, ask your plan administrator for the application for this coverage.

Do you wish to apply for Optional Accidental Death and Dismemberment Insurance for you or your spouse? (if provided)  Yes  No

Employee Amount \_\_\_\_\_ Spouse Amount \_\_\_\_\_

### DEPENDENT ENROLLMENT

Please list all dependents (spouse, children, overaged dependent children at school and disabled children). **See Relationship Codes below for dependents\*.**

Last Name	First Name	Relationship	Sex	Date of Birth (yyyy/mm/dd)	Effective Date (yyyy/mm/dd)

\* S - Spouse      C - Child      O - Other

Other is used to specify a child with disabilities who is not subject to age limitations.

**NOTE:** When enrolling a common-law spouse, please indicate number of months of co-habitation \_\_\_\_\_

### OVERAGE DEPENDENT ENROLLMENT

You must apply for coverage for each child who has reached or is about to reach the age limit under your benefit plan, who is a full-time student and solely dependent on you for support. (Please attach proof). **(You must re-apply at the beginning of each academic year for coverage to continue to maximum age as applicable under your benefit plan).**

(Complete for each overage child who is a student)

Last Name	First Name	School	Effective Date of Enrollment to (yyyy/mm/dd)	from (yyyy/mm/dd)

### SECTION 3 - BENEFICIARY DESIGNATION

#### BENEFICIARY DESIGNATION

If you are a resident of Quebec the appointment of a spouse as beneficiary is irrevocable unless designated revocable. The appointment of any other beneficiary is revocable. If you are not a resident of Quebec any appointment is revocable unless designated irrevocable. The appointment shall apply to all benefits for which the appointment is provided under the above numbered group contract. If the appointed beneficiary is a minor you will need to appoint a trustee.

Beneficiary – Name	Relationship	Date of Birth (yyyy/mm/dd)	revocable or irrevocable (please hand write)
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Beneficiary – Name	Relationship	Date of Birth (yyyy/mm/dd)	revocable or irrevocable (please hand write)
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Beneficiary – Name	Relationship	Date of Birth (yyyy/mm/dd)	revocable or irrevocable (please hand write)
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You may also wish to designate a "Contingent Beneficiary(ies)" to receive any proceeds under this group policy if all of the Primary Beneficiary(ies), named above, 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 Beneficiary(ies) you choose to name. Should there not be any surviving beneficiaries at the time of your death, proceeds will be paid to your estate.

Contingent Beneficiary – Name	Date of Birth (yyyy/mm/dd)	Relationship
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Contingent Beneficiary – Name	Date of Birth (yyyy/mm/dd)	Relationship
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If any named beneficiary(ies) is/are a minor (under the age of majority) you may want to name a trustee to receive the proceeds in trust for the minor(s) until he/she attains the age of majority. The age of majority varies from province to province.

Appointed Trustee – Name (if applicable)	Date of Birth (yyyy/mm/dd)	Relationship
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Signature of Plan Member (in full)	(yyyy/mm/dd)
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#### CHANGE OF BENEFICIARY

Beneficiary – Name	Relationship	Date of Birth (yyyy/mm/dd)	revocable or irrevocable (please hand write)
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Beneficiary – Name	Relationship	Date of Birth (yyyy/mm/dd)	revocable or irrevocable (please hand write)
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I make the above noted beneficiary designation and I reserve the right to change this designation at a later date as may be indicated in the change(s) of beneficiary section.

Signature of Plan Member (in full)	(yyyy/mm/dd)
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#### CHANGE OF PLAN MEMBER NAME

Marriage       Other Reason \_\_\_\_\_

New Name	First	Last	Date of Change (yyyy/mm/dd)
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### SECTION 4 - DECLARATION AND AUTHORIZATION

I authorize Manulife Financial to collect, use and disclose personal information concerning me and/or my dependent(s) (where applicable) for the purpose of determining eligibility for Manulife Financial products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Manulife Financial's Privacy Policy and Privacy Information Package, available at [www.manulife.ca/groupbenefits](http://www.manulife.ca/groupbenefits) or by request.

I request my employer to arrange for the issuance of group coverage for which I am or may become eligible as indicated herein, and, I authorize my employer to deduct from my earnings the contributions, if any, required for the coverage. Should the above Employee Identification Number represent my Social Insurance Number for purposes of administration of my group benefit plan. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the purposes authorized herein.

I understand that on the date my insurance becomes effective with Manulife Financial that I must be actively-at-work. I also understand that on the date dependent's insurance becomes effective with Manulife Financial that they cannot be confined to home or hospital.

I declare that the statements I have made on this form are complete and true I understand that if any statement is incomplete or false, my coverage may be voided.

Signature of Plan Member (in full)	(yyyy/mm/dd)
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