coverme™

Application for **FollowMe™ Life** Insurance
The Manufacturers Life Insurance Company

AIR MILES® Collector #: 8

1XX08 001 WSEXX

Primary Applicant Information

Last Name _____

First Name _____ Initial _____

Address _____

City _____

Province _____ Postal Code _____

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

Telephone (Res.) ___ (_____) _____

Telephone (Bus.) ___ (_____) _____

Please provide information about your current or recently ended group life plan:

Employer Name _____

Insurance Company _____

Life Benefit Amount _____ Date Benefits End(ed) _____ (DD / MM / YYYY)

Group and Identification Numbers _____

Do you intend to replace any existing life insurance coverage (other than the coverage you had through an employer group benefits plan) with this insurance coverage? ☐ Yes ☐ No

If "Yes", please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us at 1-888-640-8658. We may not be able to issue an insurance policy if replacement is indicated.

Spouse Information (if applying for coverage)

Last Name _____

First Name _____ Initial _____

Address _____

City _____

Province _____ Postal Code _____

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

Telephone (Res.) ___ (_____) _____

Telephone (Bus.) ___ (_____) _____

Please provide information about your coverage under the primary applicant's current or recently ended group life plan:

Employer Name _____

Insurance Company _____

Life Benefit Amount _____ Date Benefits End(ed) _____ (DD / MM / YYYY)

Group and Identification Numbers _____

Do you intend to replace any existing life insurance coverage (other than the coverage you had through an employer group benefits plan) with this insurance coverage? ☐ Yes ☐ No

If "Yes", please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us at 1-888-640-8658. We may not be able to issue an insurance policy if replacement is indicated.

Choice of Coverage

I apply for FollowMe™ Life coverage:

Amount of coverage $ _____

(Available from $25,000 to $200,000; you are eligible to apply for FollowMe Life coverage equal to or less than your group life coverage amount.)

I confirm my smoking status as:

☐ Smoker ☐ Non-Smoker*

*Non-smoker status applies to people who have not used tobacco, tobacco cessation products or marijuana in the past 12 months. Smoker status is determined when your coverage is approved.

Choice of Coverage

I apply for FollowMe™ Life coverage:

Amount of coverage $ _____

(Available from $25,000 to $200,000; you are eligible to apply for FollowMe Life coverage equal to or less than your coverage amount under the primary applicant's group life plan.)

I confirm my smoking status as:

☐ Smoker ☐ Non-Smoker*

*Non-smoker status applies to people who have not used tobacco, tobacco cessation products or marijuana in the past 12 months. Smoker status is determined when your coverage is approved.

Beneficiary Information

Beneficiary on Primary Applicant's Coverage

I hereby designate the individual(s) named as beneficiary below to receive any death benefit payable with respect to the coverage applied for.

Beneficiary(ies):

1. Last Name _____
   First Name _____
   Relationship to Primary Applicant _____ % of Benefit _____
2. Last Name _____
   First Name _____
   Relationship to Primary Applicant _____ % of Benefit _____

Beneficiary Information

Beneficiary on Spouse's Coverage

I hereby designate the individual(s) named as beneficiary below to receive any death benefit payable with respect to the coverage applied for.

Beneficiary(ies):

1. Last Name _____
   First Name _____
   Relationship to Spouse _____ % of Benefit _____
2. Last Name _____
   First Name _____
   Relationship to Spouse _____ % of Benefit _____

Continued on Page 2

Beneficiary Information (continued)

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(ies) _____

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. 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.

Beneficiary Information (continued)

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(ies) _____

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. 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.

Payment Options – Pay monthly by credit card or PAD and collect AIR MILES® reward miles

I/We hereby authorize Manulife to debit the initial premium, $ _____ , and subsequent premiums, from my/our:

Option #1

☐ Credit Card Account:

Credit Card Billing Frequency: ☐ Monthly - with AIR MILES® reward miles
☐ Annually - without AIR MILES reward miles

Option #2

☐ Pre-Authorized Debit (PAD) – monthly with AIR MILES® reward miles

Important: for verification purposes, we require a sample cheque marked "VOID".

Payment Information

Payment Information

For Credit Card payment options

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Account Number _____ Expiry Date _____ (MM / YYYY)

Name of Cardholder _____ Signature of Cardholder _____

For Pre-Authorized Debit (PAD) payment options

Name of Account holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Transit Number _____

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ Other

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.

Continued on Page 3

Payment Authorization

Payment Authorization

For Credit Card payment options

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.

Name of Cardholder _____ Signature of Cardholder _____

Second signature if joint account _____ Dated _____
DD / MM / YYYY

For Pre-Authorized Debit (PAD) payment options

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 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.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-COVER ME® (1-877-268-3763), www.coverme.com or write to us at Manulife, PO 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.cdnpay.ca.

Name of Account holder _____ Signature of Account holder _____

Second signature if joint account _____ Dated _____
DD / MM / YYYY

Declaration – Please read carefully before signing.

I/We, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company. I/We declare that the statements contained in this application 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 understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date is a risk not covered. I/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that insurance will take effect on the date the application and payment of the first premium are received by Manulife at its office.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death.

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.

By signing this application, each applicant declares that he/she is not currently ill or injured or, where the Primary Applicant's group life plan has already ended, was not ill or injured at the time the group life plan ended.

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

Signed at _____ Dated _____ Applicant's Signature _____
(city, province) DD / MM / YYYY

Signed at _____ Dated _____ Spouse's Signature _____
(city, province) DD / MM / YYYY (if spouse is applying for coverage)

Plan underwritten by **The Manufacturers Life Insurance Company.**

Manulife