coverme™

WSE

Application for FollowMe™ Health Insurance

AIR MILES® Collector #: 8

The Manufacturers Life Insurance Company

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?

☐ Home Telephone ☐ Office Telephone

Date of Birth _____ DD / MM / YYYY _____ Age _____

☐ Male ☐ Female

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.

Please provide additional information regarding your employer-sponsored or group health plan, your overall participation in which must have recently or will soon come to a complete end:

Employer Name _____

Insurance Company _____

Group Plan Participation End Date _____ DD / MM / YYYY _____

Group and Identification Numbers _____

Co-Applicant's

Last Name _____

First Name _____ Initial _____

Telephone (Res.) (_____) _____

Telephone (Bus.) (_____) _____

If additional information is required, how may we contact you?

☐ Home Telephone ☐ Office Telephone

Date of Birth _____ DD / MM / YYYY _____ Age _____

☐ Male ☐ Female

Please provide additional information regarding your employer-sponsored or group health plan, your overall participation in which must have recently or will soon come to a complete end (if different than that of Primary Applicant):

Employer Name _____

Insurance Company _____

Group Plan Participation End Date _____ DD / MM / YYYY _____

Group and Identification Numbers _____

Note for Quebec Residents:

Is this application intended to replace current coverage other than your current or recently ended group health plan? ☐ Yes ☐ No

If you intend to replace coverage other than your current or recently ended group health plan, do not cancel your existing coverage. Manulife may not be able to issue a policy where replacement of an existing insurance product is intended. The prescription drug coverage available under this plan is limited to costs not covered by the RAMQ Prescription Drug Insurance Plan. It is not intended to be a replacement for the RAMQ Plan. In order to be eligible for coverage under this Plan, you must have a provincial health card and be registered under the RAMQ Prescription Drug Insurance Plan, or have equivalent coverage under a group plan.

Part B – Dependants to be Covered

Last Name	First Name	Sex	Birth Date DD/MM/YYYY	Age
D E P E N D A N T			DD/MM/YYYY	
D E P E N D A N T			DD/MM/YYYY	
D E P E N D A N T			DD/MM/YYYY	

Part C – Plan Choice

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

FollowMe Travel Add-On: Available only with one of the above plans. Both applicant & co-applicant must be under age 69 at effective date of coverage. ☐ FollowMe Travel 15 days ☐ FollowMe Travel 30 days

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

Primary Applicant's Beneficiary

Last Name _____

First Name _____

Relationship to Primary Applicant _____

Co-Applicant's Beneficiary

Last Name _____

First Name _____

Relationship to Co-Applicant _____

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 becomes of age.

Trustee:

Last Name _____ First Name _____

Relationship to Beneficiary _____

Trustee:

Last Name _____ First Name _____

Relationship to Beneficiary _____

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.

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

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

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

PAYMENT INFORMATION

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.

For Credit Card payment options

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Account Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date ☐☐☐☐

Name of Cardholder _____ Signature of Cardholder _____

PAYMENT AUTHORIZATION

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

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

Applicant's Declaration and Authorization

ALL APPLICANTS MUST COMPLETE THIS SECTION

I/We the undersigned applicant(s) hereby apply for insurance to The Manufacturers Life Insurance Company. 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/We 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 Primary Applicant _____ Dated DD / MM / YYYY

Signature of Co-Applicant _____ Dated DD / MM / YYYY

Plan underwritten by
The Manufacturers Life Insurance Company.

Manulife