Manulife Financial

For your future™

Please send the completed form to your plan administrator.

Group Benefits

◯ Request for Over-Age Student Dependant Coverage (Complete sections 1, 2 and 4)

◯ Termination of Over-Age Student Dependant Coverage (Complete sections 1, 3 and 4)

1 General information

Plan sponsor name	Plan number(s)		Plan member ID
Last name of plan member	First name		Middle initial
Address of plan member	City	Province	Postal code

Last name of dependant	First name	Relationship to plan member	Dependant's date of birth (dd/mmm/yyyy)	Sex ◯ Male ◯ Female

Address of dependant	City	Province	Postal code

2 Full-time student

Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the next school year, the upper limit of the dependant definition age, or until coverage is terminated.

Name of accredited school/college/university	Location of school/college/university
Date school year: Begins (dd/mmm/yyyy)	Ends (dd/mmm/yyyy)

3 Termination of over-age student coverage

This only applies if you have over-age dependant children who are no longer students.

◯ I wish to terminate ALL coverage for DEPENDANT NAME	Effective date of termination (dd/mmm/yyyy)
Reason for termination	

4 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. **I designate** the person(s) named under Beneficiary Designation, as my beneficiary.

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.

Please sign and date here.

Plan member's signature	Date signed (dd/mmm/yyyy)

Ce document est aussi disponible en français sur demande – GL5193F