Selkirk College

MANULIFE GROUP BENEFITS ENROLMENT OR RE-ENROLMENT APPLICATION

Completed forms must be returned to **benefits@selkirk.ca**

Form MUST be filled out using Adobe Acrobat. Do not use Apple Preview.

EMPLOYER SECTION

Plan sponsor name: **Selkirk College**			Plan contract number: **83247**	
Billing division:	Account/Division number:		Plan member's certificate number:	
Do you want the waiting period added to the hire date? ☐ Yes ☐ No			Permanent hire date (dd/mmm/yyyy):	
Re-hire date (dd/mmm/yyyy):	If a re-hire, date previous employment ended (dd/mmm/yyyy):			
Occupation:	Class:	Hours worked/week:	Salary $	Frequency:

I certify that the **plan member** listed below is **actively at work** at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

PLAN ADMINISTRATOR SIGNATURE

DATE SIGNED (DD/MMM/YYYY)

Is evidence of insurability required? ☐ Yes ☐ No	**If yes, please complete form GLoo04E and send to Manulife for processing.**

(In order to determine if evidence of insurability is required, please refer to your contract.)

EMPLOYEE SECTION

**Select male, female or non-binary (intersex) consistent with your current biological sex. For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception. Manulife may follow up with applicants who select non-binary for additional medical or other information.*

1. PLAN MEMBER INFORMATION

Plan member's last name:	First name:	
Date of birth (dd/mmm/yyyy):	Sex* ☐ Male ☐ Female ☐ Non-binary	Province of residence:
Language: ☐ English ☐ French	Do you have a spouse? (married, common law or civil union?): ☐ Yes ☐ No	
Provincial Health Number:		

2. PLAN MEMBER ADDRESS

Number, Street, Apt:		PO Box:
City:	Province:	Postal Code:

3. APPLICATION FOR COVERAGE

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

I am applying for Extended Health Care for:

- ☐ Myself only
- ☐ Myself and 1 dependant (child or spouse)
- ☐ Myself and 2 or more dependants (spouse and children)
- ☐ None, because my spouse has coverage

I am applying for Medical Travel Benefits for:

- ☐ Myself only
- ☐ Myself and 1 dependant (child or spouse)
- ☐ Myself and 2 or more dependants (spouse and children)
- ☐ None, because my spouse has coverage

I am applying for Dental Care for:

- ☐ Myself only
- ☐ Myself and 1 dependant (child or spouse)
- ☐ Myself and 2 or more dependants (spouse and children)
- ☐ None, because my spouse has coverage

Selkirk College

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4. COORDINATION OF BENEFITS

This section is required if you are applying for coverage on your dependants.

Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? ☐ Yes ☐ No

If yes, please provide the following details.

Name of other insurer:		
Insured's last name:	First name:	Date of birth (dd/mmm/yyyy):
Effective date of coverage (dd/mmm/yyyy):	Identification/certificate number:	Policy number:

In cases where the information is not complete a default value will be applied.

Please indicate type of coverage under other plan:

Extended Health Benefits ☐ Single ☐ Couple ☐ Family ☐ None **Dental Care** ☐ Single ☐ Couple ☐ Family ☐ None

Medical Travel Benefits ☐ Single ☐ Couple ☐ Family ☐ None

5. DEPENDANT INFORMATION

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5 Application for coverage.

Spouse last name:	First name:	Date of birth (dd/mmm/yyyy):
Gender:	If common law, please provide the effective date of cohabitation (dd/mmm/yyyy):	

**To apply for over-age disabled dependant coverage, please complete form GL0514E.
If there is not enough room to **list your dependants**, attach details on a separate sheet.

Last name	First name	Date of birth (dd/mmm/yyyy)	Male	Female	Non-binary	Over-age student	Over-age disabled dependant***

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6. AUTHORIZATION AND CONSENT

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.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. I understand such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

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/planmember, or from my Plan Sponsor.

PLAN MEMBER SIGNATURE

DATE SIGNED (DD/MMM/YYYY)

Selkirk College

MANULIFE GROUP BENEFITS BENEFICIARY DESIGNATION

All sections of this page should be completed as it will replace any prior designations.

Form MUST be filled out using Adobe Acrobat. Do not use Apple Preview.

1. PLAN MEMBER INFORMATION

Plan sponsor name: **Selkirk College**	Plan contract number:	Plan member certificate number:
Full legal name:	Province of residence:	Date of birth (dd/mmm/yyyy):

2. PRIMARY BENEFICIARY

List all primary beneficiaries for Basic Life and/or Basic Accidental Death. Percentages must total 100% to be valid.

Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):	Percentage:
Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):	Percentage:
Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):	Percentage:

If spouse is beneficiary, the designation is: ☐ **Revocable** ☐ **Irrevocable**

Irrevocability

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form.
You are responsible for ensuring the validity of your designation.

3. OPTIONAL COVERAGE (IF APPLICABLE)

Plan Contract Number:	

List all primary beneficiaries for Basic Life and/or Basic Accidental Death. Percentages must total 100% to be valid.

Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):	Percentage:
Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):	Percentage:
Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):	Percentage:

If spouse is beneficiary, the designation is: ☐ **Revocable** ☐ **Irrevocable**

Irrevocability

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form.
You are responsible for ensuring the validity of your designation.

4. CONTINGENT BENEFICIARY

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, 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 beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):
Full legal name:	Relationship to plan member:	Date of birth (dd/mmm/yyyy):

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5. TRUSTEE APPOINTMENT

Complete if any beneficiary named is under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

6. DECLARATION AND AUTHORIZATION

Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid.
A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original.

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.
At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file.

Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

I acknowledge that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.

PLAN MEMBER SIGNATURE

DATE SIGNED (DD/MMM/YYYY)

Manulife Financial assumes no responsibility for the validity or sufficiency of the content provided by you. The items 'you' and 'yours' refer to the plan member, the term "Plan Sponsor" refers to the entity that offers the group benefits plan, such as an employer.

WHAT IS THE PURPOSE OF A BENEFICIARY?

If you intend for some or all of your death benefit to go to specific individuals, it is important to make sure that you plan ahead and select those beneficiaries. Having an up-to-date beneficiary designation will make this possible by listing your primary and contingent beneficiaries and intended allocations.

Beneficiary: *the person, people or entity who will receive any death benefit from the basic or optional coverage you have selected through your group benefits plan that becomes payable upon your death. Basic and optional beneficiaries may differ.*

TYPES OF BENEFICIARY – PRIMARY VS. CONTINGENT

Primary: *the person, people or entity you choose to receive the death benefits. If you choose more than one beneficiary, you will need to indicate what percentage of the benefit you would like each person to receive. When multiple primary beneficiaries are named, the total of the percentages allocated to each primary beneficiary must add up to 100%.*

Contingent: *the person, people or entity you designate to receive the death benefits if all of the primary beneficiaries die before you. If you select more than one contingent beneficiary, the benefit will be split evenly between the contingent beneficiaries.*

WHAT HAPPENS TO THE DEATH BENEFIT WHEN...

Q: The primary beneficiary dies before you and no contingent beneficiary is named?

A: The death benefit will be paid to your estate.

Q: The primary beneficiary dies before you, but there is a contingent beneficiary(ies) designated.

A: The benefit will be paid to the contingent beneficiary(ies).

Q: You assign two primary beneficiaries, and one beneficiary dies before you, and you have not updated your Beneficiary Form information?

A: The entire death benefit that would have been paid to the deceased beneficiary will be paid to the surviving primary beneficiary.

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IRREVOCABLE VS. REVOCABLE

Irrevocable: *the beneficiary you choose cannot be changed without the written permission of that individual.*

For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you will not be able to change the beneficiary designation without a completed release form from them.

Revocable: *A revocable beneficiary means that the beneficiary you choose can be changed at any time without the permission of that individual.*

For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you can then change that beneficiary designation without asking for that person's permission.

WHAT IS THE PURPOSE OF A BENEFICIARY?

If a benefit becomes payable to a minor who is named as a primary or contingent beneficiary, the benefit can only be paid on behalf of the minor to a trustee or guardian for property, otherwise it will be paid into court to be held until the beneficiary has reached the age of majority for your specific province. It is important therefore, if you are choosing a beneficiary who is a minor at the time of the designation to also name a trustee.

If a minor has been designated as an irrevocable beneficiary, the policy is automatically frozen until the beneficiary has reached the age of majority for your specific province. A parent, guardian or trustee cannot consent to a beneficiary change on behalf of a minor.

Minor: *a person named as a beneficiary who is under the age of majority for your specific province.*

Trusteer: *a person appointed by you to hold the minor's proceeds in trust until the minor reaches the age of majority for your specific province.*

Tutor: *a tutor acts like a trustee.*