Manulife Financial

Group Benefits
Evidence of Insurability - Head Office Plans

1 Plan sponsor information

Plan contract number(s)

Division number

Plan member certificate number

Plan sponsor

Plan administrator name

E-mail address

2

Plan member's name (last, first and middle initial)

4 Dependant information

Please provide the following information for each dependant to be insured.

If you have more than three children, please attach separate sheet (signed and dated) and include all personal information as requested above.

Child's name (last, first and middle initial)

Sex		Height		Weight
Male Female		__________ m __________ ft	__________ cm __________ in	◯ kg ◯ lb

Have you lost or gained more than 10 lbs. during the last 12 months? No If "Yes", please answer the following:

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **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 understand** that any Coverage shall not become effective until approved by Manulife.
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 certificat(appdt15 gwTT61079Cov7(id .)Tj/TT6(2 0.803 TDlher02 ning)-43pro4 mng)-43l