



The Manufacturers Life Insurance Company
The Retired Women Teachers of Ontario
 APPLICATION FOR HOSPITAL AND HOME CARE AND
 PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLANS

Branch:

When applying for coverage, please follow these steps:

- 1) Complete, sign and date the application. **Note that PARTS D & E must be completed in full if, as a member, you have been retired for more than one year, or you are the spouse of a member.**
- 2) If you choose to have premiums paid by Pre-Authorized Debit (PAD), please ensure that you have also signed PART F and enclose a blank cheque marked VOID. If you choose to pay by cheque, you will be billed for payment upon approval of your application.
- 3) Please mail your application to: Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

Part A – General Information

Primary Applicant

Last Name _____ First Name _____ Initial _____
 Home Address _____ Unit/Apt. _____ City _____ Province _____ Postal Code _____
 Date of Birth DD/MM/YYYY Date of Retirement DD/MM/YYYY Telephone Number _____
 Fax Number _____ Email _____

Spouse Information (if applying for Spouse coverage)

Spouse's Last Name _____ First Name _____ Initial _____
 Spouse's Date of Birth DD/MM/YYYY Telephone Number _____ Fax Number _____
 Email _____

Does each applicant have provincial/territorial health care coverage? Yes No

Part B – Plan Choice

Applicant

I am applying for (Check all that apply): Hospital & Home Care Plan Personal Accidental Death & Dismemberment Plan

If applying for Personal Accidental Death & Dismemberment Plan, please choose a coverage amount based on your age.

| | | | | | | | | |
|----------------------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|
| Under Age 70: | \$25,000 | \$50,000 | \$75,000 | \$100,000 | \$125,000 | \$150,000 | \$175,000 | \$200,000 |
| Age 70-79: | \$12,500 | \$25,000 | \$37,500 | \$50,000 | \$62,500 | \$75,000 | \$87,500 | \$100,000 |
| Age 80-84*: | \$6,250 | \$12,500 | \$18,750 | \$25,000 | \$31,250 | \$37,500 | \$43,750 | \$50,000 |

*Coverage terminates at age 85.

Spouse

I am applying for (Check all that apply): Hospital & Home Care Plan Personal Accidental Death & Dismemberment Plan

If applying for Personal Accidental Death & Dismemberment Plan, please choose a coverage amount based on your age.

| | | | | | | | | |
|----------------------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|
| Under Age 70: | \$25,000 | \$50,000 | \$75,000 | \$100,000 | \$125,000 | \$150,000 | \$175,000 | \$200,000 |
| Age 70-79: | \$12,500 | \$25,000 | \$37,500 | \$50,000 | \$62,500 | \$75,000 | \$87,500 | \$100,000 |
| Age 80-84*: | \$6,250 | \$12,500 | \$18,750 | \$25,000 | \$31,250 | \$37,500 | \$43,750 | \$50,000 |

*Coverage terminates at age 85.

Part C – Beneficiary Information (Personal Accidental Death & Dismemberment Coverage)

Applicant Beneficiary(ies):

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

- | | |
|------------------------------------|--------------|
| 1. Last Name | First Name |
| Relationship to you, the applicant | % of Benefit |
| 2. Last Name | First Name |
| Relationship to you, the applicant | % of Benefit |

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:

- | | |
|---------------------------------|--------------|
| 1. Last Name | First Name |
| Relationship to the beneficiary | % of Benefit |

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.

Spouse Beneficiary(ies):

In accordance with the Group Policy, the Applicant is automatically the beneficiary on any Spouse Term Life or Accidental Death Coverage, unless the Applicant designates a beneficiary to receive the proceeds. Only the Applicant has the right to designate a beneficiary and may do so below if he/she wishes to.

I (the Applicant) hereby designate the individual(s) named below to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Applicant.

- | | |
|---------------------------|--------------|
| 1. Last Name | First Name |
| Relationship to applicant | % of Benefit |
| 2. Last Name | First Name |
| Relationship to applicant | % of Benefit |

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:

- | | |
|---------------------------------|--------------|
| 1. Last Name | First Name |
| Relationship to the beneficiary | % of Benefit |

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.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Part F – Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, \$ _____, using my/our: _____
Pre-Authorized Debit (PAD)

Important: Initial payment will be taken on the **day approved** (not the effective date). Future payments will be taken on the first of each month.

Subsequent payments will be made by:

Option #1 Pre-Authorized Debit (PAD)
PAD Billing Frequency: Monthly Semi-Annually Annually

Important: For verification purposes, we require a sample cheque marked 'VOID'.

Option #2 Direct Billing
Direct Billing Frequency: Semi-Annually Annually

To apply securely using your credit card, contact our licensed insurance advisors at 1-877-222-7340.

Payment Information

For pre-authorized debit (PAD) payment option

Name of Account Holder _____ Financial Institution _____
Address _____ City/Town _____
Bank Account Number _____ Transit Number _____
Type of Account: Personal Chequing Chequing/Savings Savings Current Direct Deposit Account 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.

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 the date 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. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-222-7340 or more_info@manulife.ca, 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.payments.ca.

Name of Account Holder _____ Signature of Account Holder _____

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

Account holder address (if different from Applicant)

Personal Information Statement

In this Statement, “you” and “your” refer to the plan member or holder of rights under the contract, the insured and the parent or guardian of any child named as insured who is under the legal age for providing consent. “We”, “us”, “our” and “the Company” refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you such as:

- Identifying information such as your name, address, telephone number(s), email address, date of birth, or driver’s licence
- Medical information that any organization or person has about you
- A copy of all driving-related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or consumer report from other organizations, persons or sources that have any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking data to administer benefits
- Other personal information we may require to administer our business relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company,
- Other sources, such as:
 - Your advisor or authorized representative(s)
 - Third parties with whom we deal in issuing and administering your plan now, and in the future
 - Public sources, such as government agencies, and Internet sites
 - Health care professionals, including medical practitioners, health care institutions, pharmacies and any other medically related facilities
 - Other insurance carriers
 - Administrators of government benefits and other benefit programs

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the plan
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons and other parties with whom we deal in issuing and administering your plan now, and in the future
- Authorized employees, agents and representatives
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your medical doctor

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

How long do we keep your information?

The longer of:

- The time period required by law and by guidelines set for the financial services industry, and
- The time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the plan unless federal or provincial laws give you this right. If you do so, a plan may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care centre at 1-877-222-7340, or write to the Privacy Officer at the address below.

Accuracy and access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question, a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer

Manulife

P.O. Box 1602

500 King Street North

Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Declaration and Authorization – Please read carefully before signing.

All applicants must complete this section.

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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third-party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application, may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality as stated in the brochure. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. Once approved, I/We understand and agree to receive our contract electronically online at manulife.ca/secureserve. I can request a paper copy of the contract by contacting customer service.

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

Signature of Applicant _____ Signed at _____ City, Province _____ Date DD/MM/YYYY

Signature of Spouse _____ Signed at _____ City, Province _____ Date DD/MM/YYYY

Send your completed application form to
Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

If you have any questions, please call toll-free
1-877-222-7340 or email **am_info@manulife.ca**.



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