Manulife

# Group Benefits
# Application for Optional Accidental Death and Dismemberment Insurance

***INSTRUCTIONS - Please print all answers***

1. *Please consult your plan administrator for type of coverage available under your plan. Check (√) the appropriate box to indicate the type of coverage for which you are applying.*

   ○ *PLAN MEMBER ONLY* ○ *PLAN MEMBER, SPOUSE AND DEPENDANTS*

2. *Please ensure that ALL SECTIONS are completed.*
   *Section 1 - Plan sponsor information - To be completed by plan administrator.*
   *Sections 2, 3, 4, 5 and 6 - Plan member information - To be completed by plan member.*

***If required, retain a photocopy for your files.***

## 1 Plan sponsor information

Plan number(s): 39954

Account number/Division

Certificate number

Class

**Annual earnings**
**$**

Plan sponsor: Okanagan College

Eligibility date (dd/mmm/yyyy)

## 2 Plan member information

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

Date of birth (dd/mmm/yyyy)

Language preference/Langue préférée ○ English/Anglais ○ Français/French

Sex ○ Male ○ Female

Province of residence

**Optional accidental death and dismemberment (AD&D) amount:**

Applicant's present amount of optional AD&D $ ______

Additional amount requested $ ______

Total amount requested $ ______

## 3 Beneficiary designation

If a beneficiary is not assigned, "ESTATE" will be assumed.

| Name of beneficiary (last, first, middle initial) | Percentage | Relationship to member |
|---|---|---|
| | % | |
| | % | |
| | % | |

Complete if the beneficiary 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.)

**Irrevocability**

**For Quebec residents only**
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
○ Revocable ○ Irrevocable

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 Spousal coverage

*Note: you will be the beneficiary of your spouse's insurance, if you are then living, otherwise the beneficiary will be your estate.*

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

Sex ○ Male ○ Female

Date of birth (dd/mmm/yyyy)

## 5 Dependant coverage

*Note: you will be the beneficiary of your dependant's insurance, if you are then living, otherwise the beneficiary will be your estate.*

Dependants are those persons that meet the definition of an eligible dependant under the terms of the contract at the time of loss.

## 6 Certification and authorization

**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 above 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/planmember**, or from my Plan Sponsor.

**Please sign and date here.**

| Plan member signature | Date signed (dd/mmm/yyyy) |
|---|---|
| | |

## 7 Mailing instructions

Please send the completed form to:
**Okanagan College**
**Human Resources**
**1000 KLO Rd**
**Kelowna, BC V1Y 4X8**