

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)

Please complete form and send to: Plan Member Administration, Manulife, PO Box 11006, Station Centre-Ville, Montreal Quebec H3C 4T8

1. Plan member information	Plan sponsor name	Plan number(s)	Plan member's certificate number
	Last name of plan member	First name	Middle Initial
	Address of plan member	City	Province Postal code

2. Full-time student information	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.			
<p>* Select male, female or non-binary consistent with your current biological sex.</p> <p>For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.</p>	Last name of dependant	First name	Relationship to plan member	Dependant's date of birth (dd/mmm/yyyy)
				Sex* <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Non-binary
	Address of dependant	City	Province	Postal code
	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	Effective date of termination (dd/mmm/yyyy)
<p>This only applies if you have over-age dependant children who are no longer students</p>	<input type="radio"/> I wish to terminate all coverage for <div style="border: 1px solid black; padding: 5px; min-height: 30px;">Reason for termination</div>

4. Plan member signature	<p>I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by 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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.</p> <p>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.</p>		
Please sign and date here.	Plan member signature	Date signed (dd/mmm/yyyy)	

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