Manulife Financial

# Group Benefits

## ◯ Request for Over-Age Dependant Coverage (Complete sections 1, 2 (if applicable), 3 and 5)

## ◯ Termination of Over-Age Dependant Coverage (Complete sections 1, 4 and 5)

*Please send the completed form to:* Plan Member Administration
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1

### 1 General information

| | | | |
|---|---|---|---|
| Plan sponsor name | Plan contract number(s) | Plan member certificate number | |
| Plan member last name | First name | Middle initial | |
| Address | City | Province | Postal code |
| Last name of dependant | First name | | |
| Relationship to plan member | Dependant's date of birth (dd/mmm/yyyy) | Sex ◯ Male ◯ Female | |
| Address of dependant | City | Province | Postal code |
| Plan administrator name | Plan administrator telephone number ( ) | | |

### 2 Disabled dependant information

If you are completing this section of the form, **please attach a report or letter from the dependant's personal physician** confirming the diagnosis and prognosis for the dependant, and the extent to which the physician determines the dependant is unable to work.

Is the **disabled dependant** a resident of your home 365 days a year? ◯ Yes ◯ No
If "No", please explain.

Has the disabled dependant ever been employed? ◯ Yes ◯ No
If "Yes", please give most recent date of employment and description of type of employment.

| Date (dd/mmm/yyyy) | Type of employment |
|---|---|
| | |

Is disabled dependant eligible for: a) benefits under a government plan? ◯ Yes ◯ No
b) Health, Dental, Disability Benefits from another group plan? ◯ Yes ◯ No

If answering "Yes" to either of the above questions, please give complete details.

Are you the sole means of the disabled dependant's support? ◯ Yes ◯ No
If "No", please explain.

### 3 Full-time student

**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.

| Name of accredited school/college/university | | Location of school/college/university |
|---|---|---|
| Date school year: | Begins (dd/mmm/yyyy) | Ends (dd/mmm/yyyy) |

## 4 Termination of over-age student coverage

This only applies if you have over-age dependant children who are no longer students.

◯ I wish to terminate ALL coverage for DEPENDANT NAME

Effective date of termination (dd/mmm/yyyy)

Reason for termination

## 5 Plan member signature

I certify that the information in this form is true and complete, to the best of my knowledge.
I authorize any health care provider, other insurance company, any type of workers' compensation board, my plan sponsor, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process this application.

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.

**Please sign here**

Signature of plan member

Date signed (dd/mmm/yyyy)

Ce document est aussi disponible en français sur demande – GL0514F