Manulife

The Manufacturers Life Insurance Company

FollowMe™ Life Insurance

91501 001 P0EX0

Application for FollowMe™ Life Insurance

Section 1: Applicant Information

Last Name | First Name | Initial | ☐ Male ☐ Female

Home Address | Unit/Apt. | City | Province | Postal Code

Date of Birth DD/MM/YYYY | Age | I confirm my smoking status as: ☐ Smoker ☐ Non-Smoker*

Home Telephone | Office Telephone | Costco Membership Number

Spouse Information (if applying for Spouse coverage)

Last Name | First Name | Initial | ☐ Male ☐ Female

Home Address | Unit/Apt. | City | Province | Postal Code

Date of Birth DD/MM/YYYY | Age | I confirm my smoking status as: ☐ Smoker ☐ Non-Smoker*

Home Telephone | Office Telephone

*Non-smoker status applies to people who have not used tobacco, tobacco cessation products including e-cigarettes or vaping products in the past 12 months. Smoker status is determined when your coverage is approved.

Section 2: Amount of Insurance Applying for

I am applying for FollowMe™ Life coverage:

Applicant

Please indicate amount you're applying for:
Available from $25,000 to $200,000.

$ _____

Spouse

Please indicate amount you're applying for:
Available from $25,000 to $200,000.

$ _____

You are eligible to apply for FollowMe Life coverage equal to or less than your group life coverage amount.

Applicant: Existing Coverage

Please provide information about your current or recently ended group life plan:

Employer Name | Life Benefit Amount | Date Benefits End(ed) DD/MM/YYYY

Insurance Company | Group and Identification Numbers

Do you intend to replace any existing life insurance coverage (other than the coverage you had through an employer group benefits plan) with this insurance coverage? ☐ Yes ☐ No

If yes, please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us at 1-866-707-4922. We may not be able to issue an insurance policy if replacement is indicated.

Spouse: Existing Coverage

Please provide information about your current or recently ended group life plan:

Employer Name | Life Benefit Amount | Date Benefits End(ed) DD/MM/YYYY

Insurance Company | Group and Identification Numbers

Do you intend to replace any existing life insurance coverage (other than the coverage you had through an employer group benefits plan) with this insurance coverage? ☐ Yes ☐ No

If yes, please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us at 1-866-707-4922. We may not be able to issue an insurance policy if replacement is indicated.

Section 3: Beneficiary Information

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):

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 spouse % of Benefit

2. Last Name First Name

   Relationship to spouse % 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.

Section 4: Payment Information

I/We hereby authorize Manulife to debit the initial premium, $, and subsequent premiums, from my/our:

☐ **Pre-Authorized Debit** (PAD) – monthly

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

To apply securely using your credit card, contact our licensed insurance advisors at **1-866-707-4922** or **am_info@manulife.ca**.

For your convenience, if you choose payment by pre-authorized debit or credit card, your future premium billings will automatically reflect the same payment method.

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 the day on which insurance premiums are due or after 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 10 days 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 Payments Canada 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.

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 1-866-707-4922 or am_info@manulife.ca, or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, ON 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 than applicant) _____

Information about MIB, LLC

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, LLC based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, LLC is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, LLC will share any information it has on file. You may review the information in your file, and request a correction if necessary, by contacting MIB, LLC at:

MIB, LLC
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

Notice on Information Provided to Costco

The Member and his/her Spouse understand and agree that Manulife will provide Costco Wholesale Canada Ltd. ("Costco") with the information set forth in the Member Information and Spouse Information Sections above, together with copies of any complaints, comments or critical remarks Manulife may receive from the Member and his/her Spouse from time to time. Costco will use this information to monitor satisfaction with the services provided by Manulife and to notify the Member and his/her Spouse of any changes to the services.

Personal Information Statement

At Manulife protecting your personal information and respecting your privacy is important to us.

"We", "us" and "our" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Why do we collect, use, and disclose your personal information?

For the purposes of establishing and managing our relationship with you, providing you with products and services, administering our business, and complying with legal and regulatory requirements.

What personal information do we collect?

Depending on the product or service, we collect specific personal information about you such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, driver's license, passport number or your Social Insurance Number (SIN)
- Financial information, investigative reports, credit bureau report, and/or a consumer report
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking and employment information
- Medical information that any organization or person has about you
- Any test that may be necessary for underwriting purposes
- Other personal information that we may require to administer your products or services and manage our relationship with you

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

Where do we collect your personal information from?

Depending on the product or service, we collect personal information from:

- Your completed applications and forms
- Other interactions between you and us
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal with in issuing and administering your products or services now, and in the future
  - Public sources, such as government agencies, credit bureaus and internet sites
  - Financial institutions
  - Your employer or Plan Sponsor and their authorized agents, consultants and plan service providers
  - The MIB, LLC (formerly known as the Medical Information Bureau)
  - Health Care Professionals, including Medical Practitioners, health care institutions, pharmacy and any other medically-related facility

What do we use your personal information for?

Depending on the product or service, we will use your personal information to:

- 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
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us make decisions and understand our customers better so we can improve the products and services we provide
- Perform audits, and investigations and protect you from fraud
- Determine your eligibility for, and provide you with details of, other products and services that may be of interest to you
- Automate processing to help us make decisions about your interactions with us, such as, applications, approvals or declines

Who do we disclose your information to?

Depending on the product or service, we disclose your personal information to:

- Persons, financial institutions, reinsurers, and other parties with whom we deal with in issuing and administering your product or service now, and in the future
- Authorized employees, agents and representatives
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- Your employer or Plan Sponsor and their authorized agents, consultants and plan service providers
- 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 doctor
- Public health authorities as required

Except where there are contractual restrictions, these people, organizations and service providers are both within Canada and outside of Canada. Therefore, your personal information may be subject to interprovincial or cross-border transfers in order to provide services to you and 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.

Withdrawing your consent

You may withdraw your consent for us to use your personal information for certain uses, subject to legal and contractual restrictions.

You may not withdraw your consent for us to collect, use, or disclose personal information we need to issue or administer your products and services. If you do so, we may not be able to provide you with the products or services requested or we may treat your withdrawal of consent as a request to terminate or refusal of the product or service.

If you wish to withdraw your consent, phone our customer care centre at **1-877-268-3763**, or write to the Privacy Officer at the address below.

Accuracy

You will notify us of any change to your contact information. If your information has changed, or if you need to make a correction of any inaccuracies to your personal information in our files, you may contact us at **1-877-268-3763**.

Access

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. Requests can be sent to: **Privacy Officer, Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**.

For more information you can review our **Canadian Privacy Policy**. Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email.

Declaration and Authorization – Please read carefully before signing.

I/We, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company. I/We declare that the statements contained in this application 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 understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date is a risk not covered. I/We have read and understand that there are exclusions and limitations on the coverage applied for, including an exclusion for pre-existing conditions. I/We understand that insurance will take effect on the date my/our properly completed application and the first premium are received by Manulife, subject to approval of the company's underwriters.

Relative to the insurance applied for, I/we, the undersigned person to be insured, hereby authorize any **licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB LLC, the group policy administrator, the insurance plan sponsor**, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person/people that has any records or knowledge of me/us or my/our health to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

I/We authorize Manulife to consult its existing files for this purpose. I/We authorize Manulife to hold a personal file about myself/us and my/our insurance coverage.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death.

I/We have read, understand and agree to the Personal Information Statement.

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

Quebec residents only:

The French version of the application was provided, I wish to complete the English version. As per Quebec law, I will receive the Certificate of Insurance in both English and French and all further related documentation will be sent exclusively in English.

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

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

Please send the completed application to:

Regular Mail:
Manulife
P.O. Box 670
Stn Waterloo
Waterloo, ON N2J 4B8

Courier:
Manulife
500 King Street
Affinity Markets New Business
Delivery Station 500-GB
Waterloo, ON N2J 4C6

If you have any questions, please call Manulife at **1-866-707-4922**.

Manulife

FollowMe™ Life Insurance is underwritten by **The Manufacturers Life Insurance Company (Manulife).**

Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.
Accessible formats and communication supports are available upon request. Visit **manulife.ca/accessibility** for more information.