Manulife Financial

Application for Change

Please print clearly and complete both pages of this form.
Please complete SECTIONS 1 & 9 for ALL changes and any other sections that are applicable to your change.
If required, retain a photocopy for your files.

1 General information

We require this information to process your request.

Plan/group number(s)	Account number(s)	Division number(s)	Certificate number

Plan Sponsor/Employer

Plan Member/Employee name (last, first, middle initial)

2 Plan Member/ Employee name change

New name (last, first, middle initial)

3 Beneficiary change

Note: The effective date of the Beneficiary change will be the date this form is signed.

◯ Change of name only
◯ Change of beneficiary

Relationship to Plan Member

Name of beneficiary (last, first, middle initial)

Signature of previous irrevocable beneficiary

For Quebec residents only
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

Note: In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If the beneficiary is shown as irrevocable, his/her consent is required to change it.

For designated beneficiaries under the age of 18.

I appoint _____ as Trustee to receive any amount due any beneficiary under the age of 18.

4 Addition of benefits

A spouse/common law spouse is considered an eligible dependent under your group plan.

Addition of Extended Health Care
I wish to ADD Extended Health Care for

◯ Myself ONLY
◯ Myself AND 1 dependent
◯ Myself and 2 or more dependents
◯ My dependents ONLY (I am already covered)

Addition of Dental Care
I wish to ADD Dental Care for

◯ Myself ONLY
◯ Myself AND 1 dependent
◯ Myself and 2 or more dependents
◯ My dependents ONLY (I am already covered)

Dependent Life ◯ I wish to add Dependent Life Insurance

Reason for Additions (Check one only)

◯ Marriage	◯ Common-law relationship	◯ Spouse's coverage cancelled
Date of marriage (dd/mmm/yyyy)	Date commenced (dd/mmm/yyyy)	Cancellation date (dd/mmm/yyyy)

◯ Other

Please give details of "Other". If necessary, attach a separate sheet.

Effective date (dd/mmm/yyyy)

5 Spousal information

This is important information for correct claims adjudication.

Complete sections 5 and 6 only if you are required to enrol your spouse and children, and you need to change information.

Spouse's sex: ◯ Male ◯ Female **Spouse's date of birth:** Date (dd/mmm/yyyy)

Are you

◯ Legally married
◯ Common-law spouse

If Common law spouse, provide the date the relationship began. Date (dd/mmm/yyyy)

Spousal Health coverage
Does your spouse have health care coverage under his/her own insurance plan?

◯ Yes
◯ No

Effective date of change (dd/mmm/yyyy)

Spouse's plan covers:
◯ Your spouse only
◯ Your spouse & yourself only
◯ Your spouse & children only
◯ Your spouse, you & your children

Spousal Dental coverage
Does your spouse have dental care coverage under his/her own insurance plan?

◯ Yes
◯ No

Effective date of change (dd/mmm/yyyy)

Spouse's plan covers:
◯ Your spouse only
◯ Your spouse & yourself only
◯ Your spouse & children only
◯ Your spouse, you & your children

FOR HEAD OFFICE USE ONLY

Plan/Group Number

Certificate Number

6 Family information

Complete this section only when you are changing information pertaining to dependents that have previously been enrolled OR when you are adding/deleting a dependent.
If more than 4 children, please attach a separate listing.

Change type code A/D/C (see below)	Effective date of change (dd/mmm/yyyy)	Spouse/child name Include last name if different from your last name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Relationship code H/W/S/C (see below)	Full-time student? (Yes or No)	Disabled dependent? (Yes or No)
		spouse		◯ M ◯ F		N/A	N/A
		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No

Change type codes: **A** = Add, **C** = Change, **D** = Delete **Relationship codes:** **H** = Husband, **W** = Wife, **S** = Common-law spouse, **C** = Child

If a dependent is disabled, please complete form GL0514E, Request for Over-Age Dependent Coverage/Termination of Over-Age Dependent Coverage.

7 Termination of all dependent coverage

This only applies if you no longer have dependents (spouse or children).

◯ I wish to terminate ALL coverage for ALL dependents.

Effective date of termination (dd/mmm/yyyy)

Reason for termination

8 Refusal of benefits

You may refuse Extended Health Care and or Dental Care for yourself and/or your dependent(s) only if covered for similar benefits under spouse's plan.

If you wish to add this coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence that the dependent(s) is/are insurable may be required.

Refusal of Extended Health Care
I do **NOT** want Extended Health Care for *(check one only)*

◯ Myself and my dependent(s)
◯ My dependent(s) ONLY

Date of refusal (dd/mmm/yyyy)

Refusal of Dental Care
I do **NOT** want Dental Care for *(check one only)*

◯ Myself and my dependent(s)
◯ My dependent(s) ONLY

Date of refusal (dd/mmm/yyyy)

Refusal of Dependent Life Insurance*

◯ I do **NOT** want Dependent Life Insurance

Date of refusal (dd/mmm/yyyy)

*Note: Refusal of this benefit is NOT ALLOWED on an AlphaPlus plan.

For Quebec residents age 65 or over

◯ I am participating in the RAMQ drug plan provided by the Quebec government
◯ I am NOT participating in the RAMQ drug plan provided by the Quebec government

9 Plan Member/ Employee signature

Please sign and date here.

I designate the person(s) named above under Section 3 - Beneficiary Change as my beneficiary.
I certify that the information in this form is true and complete, to the best of my knowledge.
If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my dependents, for the purposes of determining their eligibility for benefits.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.
If applicable, I authorize my employer to make deductions from my pay for my group benefits.

Plan Member's/Employee's signature

Date signed (dd/mmm/yyyy)

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, representatives and reinsurers 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.

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Multiple Group No.	Effective date of Insurance dd/mmm/yyyy	CLASS	MODE	SAL	LIFE	A D & D	WI	LTD	EHC	DEN	DEP. LIFE	OCC	DIV	COB	DRUG PLAN	LATE EE	LATE DEP	MNL	CII EVA
Multi Accts														Remove Name		Cov Indicator		Expiry date	
EXCESS									HCSA		SENT NOTE							Initials	

La version française du document se trouve à l'adresse www.manuvie.com/assurancecollective.