

<b>WSF</b>	Advisor ID: SB000
	Advisor Name: Special Benefits Insurance Services
	Advisor Email: general@sbis.ca



# Application for FollowMe™ Health Insurance

## Part A – General Information

### Primary Applicant's

AIR MILES®  
Collector #: 8

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ Suite/Apt. No. \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ Telephone (Office) \_\_\_\_\_

If additional information is required, how may we contact you?  Home Telephone  Office Telephone

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Does each applicant have provincial/territorial healthcare coverage?\*  Yes  No

\*All applicants must have coverage under a provincial/territorial healthcare and Government Health Insurance Plan in order to be eligible for this insurance product. If anyone on the application does not meet this requirement, please contact our Customer Service for more information.

Please provide additional information regarding your employer-sponsored or group health plan, your overall participation in which must have recently or will soon come to a complete end:

Employer Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group Plan Participation End Date \_\_\_\_\_ Group No. \_\_\_\_\_ Identification No. \_\_\_\_\_

### Co-Applicant's

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ Telephone (Office) \_\_\_\_\_

If additional information is required, how may we contact you?  Home Telephone  Office Telephone

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Please provide additional information regarding your employer-sponsored or group health plan, your overall participation in which must have recently or will soon come to a complete end (if different than that of Primary Applicant):

Employer Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group Plan Participation End Date \_\_\_\_\_ Group No. \_\_\_\_\_ Identification No. \_\_\_\_\_

### Note for Quebec Residents:

Is this application intended to replace current coverage other than your current or recently ended group health plan?  Yes  No

If you intend to replace coverage other than your current or recently ended group health plan, do not cancel your existing coverage. Manulife may not be able to issue a policy where replacement of an existing insurance product is intended. The prescription drug coverage available under this plan is limited to costs not covered by the RAMQ Prescription Drug Insurance Plan. It is not intended to be a replacement for the RAMQ Plan. In order to be eligible for coverage under this Plan, you must have a valid provincial/territorial health card and Government Health Insurance Plan and be registered under the RAMQ Prescription Drug Insurance Plan, or have equivalent coverage under a group plan.

## Part B – Dependants to be Covered

Last Name	First Name	Sex	Birth Date dd/mm/yyyy	Age

If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

## Part C – Plan Choice

I/We apply for FollowMe™ Health:  Basic  Enhanced  Enhanced Plus  Premiere

**FollowMe Travel Add-On:** Available only with one of the above plans.  FollowMe Travel 15 days  FollowMe Travel 30 days

Both applicant & co-applicant must be under age 70 at effective date of coverage.

## Part D – Beneficiary Designation

When you apply, we designate your estate as the beneficiary for the Accidental Death and Dismemberment benefit. Your welcome package includes a form you can use to change your beneficiary.

## Part E – Payment Options

### Initial Payment:

I/We hereby authorize Manulife to debit the initial two (2) months premium, \$ \_\_\_\_\_ from my/our:

Option #1 – Financial Services Account (Pre-Authorized Debit)  Option #2 – Credit Card Account

### Subsequent Payments will be made by:

Option #1 – Pre-Authorized Debit (PAD) from my/our Financial Services Account

PAD Billing Frequency:  Monthly  Semi-Annually (2% savings)  Annually (4% savings)

Important: for verification purposes, we require a sample cheque marked 'VOID'. Please complete Part F.

Option #2 – Credit Card Account

Credit Card Billing Frequency:  Monthly  Semi-Annually  Annually

Please note: billing frequency savings are not available for credit card payment options. Please complete Part F.

Option #3 – Direct Billing

Direct Billing Frequency:  Semi-Annually (2% savings)  Annually (4% savings)

## Part F – Payment Information and Authorization

### Payment Information

#### For Pre-Authorized Debit (PAD) payment options

Name of Account holder \_\_\_\_\_ Financial Institution \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_

Bank Account Number \_\_\_\_\_ Transit Number \_\_\_\_\_ Institution Number \_\_\_\_\_

**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.

## Part F – Payment Information and Authorization (continued)

### For Credit Card payment options

Credit Card:  Visa  MasterCard  American Express

Account Number \_\_\_\_\_ Expiry Date \_\_\_\_\_

Name of Cardholder \_\_\_\_\_ Signature of Cardholder \_\_\_\_\_

### Payment Authorization

#### For Pre-Authorized Debit (PAD) payment options

I/We hereby authorize Manulife to make a withdrawal from my/our bank account on the day on which insurance premiums are due for insurance premiums due on 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 further 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 the Canadian Payments Association 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](http://www.payments.ca). If you have any questions about withdrawals from your bank account, contact us at 1-800-268-3763, or [more\\_info@manulife.com](mailto:more_info@manulife.com) or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario 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](http://www.payments.ca).

Name of Account holder \_\_\_\_\_ Signature of Account holder \_\_\_\_\_

Second signature if joint account \_\_\_\_\_ Dated \_\_\_\_\_

#### For Credit Card payment options

I/We hereby authorize Manulife to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This Authorization may be terminated by either Manulife or by me/us through written notice.

Manulife may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A \$25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder \_\_\_\_\_ Signature of Cardholder \_\_\_\_\_

Second signature if joint account \_\_\_\_\_ Dated \_\_\_\_\_

### Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services, and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn. 500-4-A, Waterloo, ON N2J 4C6.

### Notice on Information provided to the AIR MILES® Reward Program

When you or your family member apply for insurance, Manulife may disclose to the AIR MILES® Reward Program your AIR MILES Collector Number in order to administer the AIR MILES Reward Program, including the management of Collector Accounts and to accurately record and update Reward Mile balances. The AIR MILES Reward Program privacy policy is available at <https://www.airmiles.ca/arrow/PrivacyPolicy>. In addition, copies of the AIR MILES Privacy Pledge are available to individuals and Collectors upon request.

The AIR MILES Reward Program does not give, rent or sell Collector lists to any organization or individual other than its affiliated Businesses, Partners, Suppliers and companies contracted to process and manage Collector transactions, redemption requests, research, analysis and communications and in all cases, only to fulfill the specified purposes. AIR MILES Collectors can opt out of receiving marketing and promotional communications in electronic, printed or verbal format, other than Collector Summaries, via their Account Profiles on airmiles.ca, by writing to the AIR MILES Reward Program at AIR MILES, Customer Care, PO Box 130, Station B, Toronto, Ontario, M5T 2T3, or by email to [privacyoffice@airmiles.ca](mailto:privacyoffice@airmiles.ca). The decision to opt out of additional communications does not affect your ability to get or use Reward Miles in the AIR MILES Reward Program. Manulife cannot guarantee the availability of Air Miles Reward Miles indefinitely.

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## Applicant's Authorization and Declaration

### All Applicants Must Complete This Section

I/We hereby acknowledge that the statements contained herein 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 and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application, may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with Manulife's Notice on Privacy and Confidentiality and Notice on Information provided to the AIR MILES® Reward Program. I/We understand and agree that coverage shall not become effective until the first of the month following final approval.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive any Accidental Death and Dismemberment proceeds payable.

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

Signed at \_\_\_\_\_ Signature of Primary Applicant \_\_\_\_\_ Dated \_\_\_\_\_

Signed at \_\_\_\_\_ Signature of Co-Applicant \_\_\_\_\_ Dated \_\_\_\_\_

## Advisor's Report • For Advisor/Agent Use Only

### You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent;
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last) _____	Advisor code SB000	Signature _____
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Please send the completed application to: **Regular Mail/Courier:** Special Benefits Insurance Services, 7th Fl - 366 Bay St, Toronto ON M5H 4B2

**Fax:** (1) 416-601-0308

**Email:** [general@sbis.ca](mailto:general@sbis.ca)

**Note:** if you are contracted through a MGA/National Account firm, please forward the completed application to their office.

Plan underwritten by The Manufacturers Life Insurance Company.

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