

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 Financial, PO Box 2026, HALIFAX NS B3J 2Z1**

1 General information	Plan sponsor name			Plan number(s)		Plan member ID	
	Last name of plan member			First name		Middle initial	
	Address of plan member			City	Province	Postal code	
	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
	Address of dependant			City	Province	Postal code	
2 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)		
3 Termination of over-age student coverage	<input type="radio"/> I wish to terminate ALL coverage for <u>DEPENDANT NAME</u>					Effective date of termination (dd/mmm/yyyy)	
This only applies if you have over-age dependant children who are no longer students.	Reason for termination						
4 Plan member signature	<p>I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("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. I designate the person(s) named under Beneficiary Designation, as my beneficiary.</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/groupbenefits, or from my Plan Sponsor.</p>						
Please sign and date here.	Plan member's signature					Date signed (dd/mmm/yyyy)	

Ce document est aussi disponible en français sur demande – GL4408F