Manulife

WSF Advisor ID: MB1066

Advisor Name: Medi-Quote Insurance Brokers Inc.

FollowMe™

Application for FollowMe™ Health Insurance

All applicants must complete parts A, B, C, D, E and F.
All applicants must complete and sign the Applicant's Authorization and Declaration.

Part A – General Information

Primary Applicant's

Last Name _____ First Name _____ Initial _____

Address _____ Suite/Apt. No. _____

City _____ Province _____ Postal Code _____

Telephone (Home) _____ Telephone (Office) _____ Email (optional) _____

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

Date of Birth _____ Age _____ ☐ Male ☐ Female

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

*All applicants must have coverage under a 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	Code	Gender	Birth Date dd/mm/yyyy	Age
		00			
		01			
		02			

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.

Manulife *Vitality*™: ☐ Helps you live healthier, earn rewards and save money. Add it to your plan and automatically save 5% on your FollowMe premiums in your first year. (Available for Primary Applicant only.)

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

IMPORTANT: Initial Payment will be taken on the day approved (not the effective date). Future payments will be taken on the first of each month.

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**

Please use the following banking information:

☐ From the cheque used to make the first payment **or** ☐ As follows: (only complete the information below if you do not have a void cheque)

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 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. If you have any questions about withdrawals from your bank account, contact us at 1-800-268-3763, or 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.

Name of Account holder _____ Signature of Account holder _____

Second signature if joint account _____ Dated _____

Account Holder Address (if different from Applicant) _____

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 may be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

Dated

Notice on Privacy and Confidentiality

In this Statement, "you" and "your" refer to the plan member or holder of rights under the contract, the insured and the parent or guardian of any child named as insured who is under the legal age for providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?
Depending on the product you have applied for, 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, or driver's licence
- Medical information that any organization or person has about you
- A copy of all driving-related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or consumer report from other organizations, persons or sources that have any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking data to administer benefits
- Other personal information we may require to administer our business relationship with you

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

Where do we collect your personal information from?
- Your completed applications and forms
- Other interactions between you and the Company,
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your plan now, and in the future
  - Public sources, such as government agencies, and internet sites
  - Health care professionals, including medical practitioners, health care institutions, pharmacies and any other medically-related facility
  - Other insurance carriers
  - Administrators of government benefits and other benefit programs

What do we use your personal information for?
We will use your personal information to:

- Help us properly 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, and issue and administer the rights under the plan
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?
- Persons and other parties with whom we deal in issuing and administering your plan now, and in the future
- Authorized employees, agents and representatives
- 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 medical doctor

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be 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.

How long do we keep your information?
The longer of:

- the time period required by law and by guidelines set for the financial services industry, and
- the time period required to administer the products and services we provide.

Withdrawing your consent
You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the plan unless federal or provincial laws give you this right. If you do so, a plan may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

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 and Access
You will notify us of any change to your contact information. 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. If you have a question, a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
500 King Street N
P.O. Box 1602
Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Manulife

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 acknowledge receipt of and agree with Manulife's Notice on Privacy and Confidentiality. I/We understand and agree that coverage shall not become effective until the first of the month following final approval and receipt of first premium payment.

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 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	Signature

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

Fax:
1-888-264-2243

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.

The Vitality Group Inc., in association with The Manufacturers Life Insurance Company, provides the Manulife *Vitality* program.

Accessible formats and communication supports are available upon request. Visit **Manulife.ca/accessibility** for more information.

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