Manulife Financial

Group Benefits
Request for Special Dependant Coverage

This form is to be completed when an employee requests coverage for a special dependant (i.e. dependant not covered by the contract such as niece, nephew, grandchild, brother, sister). Completion of this form does not guarantee that coverage will be granted. Upon review of your request, we will notify the plan administrator of our decision.

1. Please ensure that ALL SECTIONS are completed.
*Section 1 - Plan sponsor statement - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR**.*
Sections 2, 3 and 4 - Plan member/dependant information - To be completed by plan member/dependant and submitted to Manulife Financial.

2. If required, retain a photocopy for your files.

1 Plan member information

Plan contract number	Plan member certificate number	Plan sponsor name
84500		**Canadian Pacific**

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

2 Information about the dependant

Name of dependant (first, middle initial, last)

Dependant's date of birth (dd/mmm/yyyy)	Sex	Relationship to plan member
	◯ Male ◯ Female	

1. Please state the date that this dependant started residing with you? Date (dd/mmm/yyyy)

2. Is the dependant a full-time student? ◯ Yes ◯ No

3. Will the dependant be a resident of your home 365 days a year? ◯ Yes ◯ No

If NO, please explain:

4. a) Are you the sole means of the dependant's support? ◯ Yes ◯ No

If NO, please explain:

b) Is the dependant claimed by you on your Federal Income Tax Return? ◯ Yes ◯ No

If NO, please explain:

5. Is the dependant covered by the Provincial Medical Plan? ◯ Yes ◯ No

If NO, please explain:

6. Please provide a brief background of situation which initiated the dependant residing with you.

Background:

3 Plan member signature

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 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:

- 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.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

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.

Please sign and date here.

Plan member's signature	Date signed (dd/mmm/yyyy)

4 Mailing instructions

Please send the completed form to:

Plan Member Administration
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1