

Flexcare® Select Application Form

Parts A, B, C, D, and Applicant's Declaration must be completed

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FOR MANULIFE FINANCIAL USE ONLY	
KEYED _____	_____
APPROVED _____	_____

AGENT ID: 00245

PART A • GENERAL INFORMATION

Applicant's First
Last Name _____ Name _____ Initial _____

Apt. Street Number
Number _____ and Name _____

City or Postal
Town _____ Province _____ Code _____

Home Telephone _____

Office Telephone _____

Fax _____ Email _____

Marital Status: Single Married Other

Occupation _____

Government Health Card Number: | | | | | | | | | | | | | | | | | |



AIR MILES #: | 8 | | | | | | | | | | | | | | | | | |

Co-Applicant's Name _____

Co-Applicant's Office Telephone _____

Co-Applicant's Fax _____ Email _____

If additional information is required during regular business hours, where may we contact you? Home Tel Office Tel Email

Are you now covered or did you have previous group health insurance coverage with Manulife Financial or any other insurance company? Yes No
If "Yes", please indicate:

1) Plan Number _____ ID Number _____

Insurance Company _____

Date coverage ended _____
dd/mm/yyyy

2) Plan Number _____ ID Number _____

Insurance Company _____

Date coverage ended _____
dd/mm/yyyy

Is this application intended to replace your existing coverage? Yes No

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Applicant's Beneficiary:

Name _____

Relationship to Applicant _____

Signature of Applicant _____

Date _____
dd/mm/yyyy

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed.

Name of Trustee _____

Relationship to Applicant _____

Signature of Applicant _____

Date _____
dd/mm/yyyy

Co-Applicant's Beneficiary:

Name _____

Relationship to Co-Applicant _____

Signature of Co-Applicant _____

Date _____
dd/mm/yyyy

Name of Trustee _____

Relationship to Co-Applicant _____

Signature of Co-Applicant _____

Date _____
dd/mm/yyyy

PLAN CHOICE

I / We apply for:

- Flexcare Select – Extended Health Care, Best Doctors® plus two of the following benefit options: [please select two (2) of the following]
 Hospital Cash Fracture Benefits Accidental Death & Dismemberment Travel Coverage (available only to applicants under 65 years)

PART B • INDIVIDUALS TO BE COVERED

First Name	Last Name	Health Card No.	Code	Sex	Birth Date dd/mm/yyyy	Age
APPLICANT			00			
CO-APPLICANT			01			
DEPENDANT CHILD			02			
DEPENDANT CHILD			02			
DEPENDANT CHILD			02			

PART C • BILLING OPTIONS

Initial Payment: I/We hereby authorize Manulife Financial to debit the initial 2 months premium, \$ _____, from my/our:

Financial Services Account Credit Card Account

Subsequent Payments: Will be made by:

Pre-Authorized Payment Plan (PAP) from My Financial Institution (Please also complete PART D below)

PAP Billing Frequency: Monthly Semi-annually (2% Discount) Annually (4% Discount)

Credit Card (Please also complete Part D below):

Visa MasterCard Amex Account # _____ Expiry Date _____ mm/yy

Cardholder _____ Signature of Cardholder _____
(if other than Applicant or Co-Applicant)

Credit Card Billing Frequency: Monthly Semi-annually Annually

Direct Billing

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

Important: For verification purposes we require a VOID cheque if a payment is being withdrawn from your financial institution.

Please Note: Billing frequency discounts are not available for Credit Card payment options.

Manulife Financial 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 NSF fee will be charged for all NSF transactions.

PART D • FINANCIAL INSTITUTION

Name of account holder(s) if different from Applicant _____

Financial Institution _____

Address _____ City/Town _____

Type of Account: Personal Chequing Chequing/Savings Savings Current Direct Deposit Account Other

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. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

For Pre-Authorized Payment and Credit Card billing options: I/We hereby authorize Manulife Financial 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 Financial or by me/us through written notice.

Signature of account holder _____ Second signature if joint account _____

APPLICANT'S DECLARATION

Plans underwritten by The Manufacturers Life Insurance Company.

Check here if you do not wish to receive further information and material on Manulife Financial products.

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

Signature of Applicant _____ Date _____
dd/mm/yyyy

Signature of Co-Applicant _____ Date _____
dd/mm/yyyy

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