FollowMe™ Health Application Form

WSF

FollowMe™ Health

Advisor ID: 00245

Advisor Name: HealthQuotes.ca Inc.

Advisor Email: inquiries@healthquotes.ca

make it count† AIR MILES® Collector #: 8

Please print in ink.

Sub-Broker ID: _____

Part A – General Information

Primary Applicant's

Last Name _____ First Name _____ Initial ___

Address _____

_____

City _____

Province _____ Postal Code _____

Telephone (Res.) ( )

Telephone (Bus.) ( )

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

☐ Home Telephone ☐ Office Telephone

Email _____

Date of Birth _____ (DD / MM / YYYY) Age _____ ☐ Male ☐ Female

Health Card No. _____

Please provide us with information about your current or recently ended group health plan:

Employer Name _____

Insurance Company _____ Date Benefits Ended _____ (DD / MM / YYYY)

Group and Identification Numbers _____

Co-Applicant's

Last Name _____ First Name _____ Initial ___

Address (if different from Primary Applicant)

_____

City _____

Province _____ Postal Code _____

Telephone (Res.) ( )

Telephone (Bus.) ( )

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

☐ Home Telephone ☐ Office Telephone

Email _____

Date of Birth _____ (DD / MM / YYYY) Age _____ ☐ Male ☐ Female

Health Card No. _____

Please provide us with information about your current or recently ended group health plan (if different from Primary Applicant):

Employer Name _____

Insurance Company _____ Date Benefits Ended _____ (DD / MM / YYYY)

Group and Identification Numbers _____

Part B – Dependants to be Covered

Last Name	First Name	Health Card No.	Code	Sex	Birth Date DD/MM/YYYY	Age
DEPENDANT			02			
DEPENDANT			02			
DEPENDANT			02			
DEPENDANT			02			
DEPENDANT			02			

FollowMe Health is offered through Manulife Financial (The Manufacturers Life Insurance Company).
Plan underwritten by The Manufacturers Life Insurance Company.

Manulife Financial

Part C – Plan Choice

I/We apply for FollowMe Health:

❑ **Basic** ❑ **Enhanced** ❑ **Enhanced Plus** ❑ **Premiere**

Part D – Beneficiary Designation

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):

Primary Applicant's Beneficiary

Last Name _____ First Name _____

Relationship to Primary Applicant _____

Co-Applicant's Beneficiary

Last Name _____ First Name _____

Relationship to Co-Applicant _____

If you designate a beneficiary under the age of 18, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed, except in Quebec where benefits will be paid directly to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee:
Last Name _____ First Name _____

Relationship to Primary Applicant _____

Trustee:
Last Name _____ First Name _____

Relationship to Co-Applicant _____

For Quebec residents only:
In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Part E – Payment Options

Initial Payment:

I/We hereby authorize Manulife Financial 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% discount) ❑ Annually (4% discount)

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 discounts are not available for credit card payment options. Please complete Part F.

Option #3 ❑ Direct Billing

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

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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 _____

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.

For Credit Card payment options

Credit Card: ❑ Visa ❑ MasterCard ❑ American Express

Account Number _____ Expiry Date _____ MM / YYYY

Name of Cardholder _____ Signature of Cardholder _____

Payment Authorization

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife Financial to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly 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 Financial may attempt to withdraw that payment again within 30 days. Manulife Financial 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 Financial 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 Financial receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.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 Financial, 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.cdnpay.ca.

Name of Account Holder _____ Signature of Account Holder _____

Second Signature If Joint Account _____ Dated _____ DD / MM / YYYY

Account Holder Address (if different from Applicant) _____

For Credit Card payment 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.

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

Name of Cardholder _____ Signature of Cardholder _____

Second Signature If Joint Account _____ Dated _____ DD / MM / YYYY

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Plan underwritten by The Manufacturers Life Insurance Company.

Manulife Financial

Applicant's Declaration

ALL APPLICANTS MUST COMPLETE THIS SECTION

This plan is 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 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.

Signature of Primary Applicant _____ Dated _____
DD / MM / YYYY

Signature of Co-Applicant _____ Dated _____
DD / MM / YYYY

Advisor's Report

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	Signature
		✖

Please send the completed application to:

Mail To:
Individual Health Applications.
5145 Steeles Ave. West,
Entrance A, Suite 202
Toronto, ON
M9L 1R5

Fax:
Individual Health Applications.
1-866-676-4581
(If the faxed application is not clear you may have to mail in the original.
If using pre-authorized payment then you must also fax us a copy of a void cheque.
For assistance please call us).

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

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 Financial 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 Financial 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 Financial at the address shown below. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 2 Queen Street East, Toronto, Ontario M5W 5M3.

Plan underwritten by The Manufacturers Life Insurance Company.
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