

# Flexcare® Select Application Form

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

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# FlexCare™

WSE



make it count™

AIR MILES® Collector # 

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## PART A • GENERAL INFORMATION

Applicant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Government Health Card Number: 

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Apt. Number \_\_\_\_\_ Street Number and Name \_\_\_\_\_

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

City or Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

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:

Home Telephone \_\_\_\_\_

1) Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_

Office Telephone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_

Date coverage ended \_\_\_\_\_

dd/mm/yyyy

Marital Status:  Single  Married  Other

2) Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Co-Applicant's Name \_\_\_\_\_

Date coverage ended \_\_\_\_\_

dd/mm/yyyy

Co-Applicant's Office Telephone \_\_\_\_\_

Co-Applicant's Fax \_\_\_\_\_ Email \_\_\_\_\_

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:

### Co-Applicant's Beneficiary:

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Relationship to Co-Applicant \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Signature of Co-Applicant \_\_\_\_\_

Date \_\_\_\_\_

dd/mm/yyyy

Date \_\_\_\_\_

dd/mm/yyyy

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.

Name of Trustee \_\_\_\_\_

Name of Trustee \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Relationship to Co-Applicant \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Signature of Co-Applicant \_\_\_\_\_

Date \_\_\_\_\_

dd/mm/yyyy

Date \_\_\_\_\_

dd/mm/yyyy

### For Quebec residents only:

In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Please check the 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.

Continued on Page 2



**PART E • PAYMENT INFORMATION AND AUTHORIZATION (continued)**

**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.

You may obtain a sample cancellation form by contacting your financial institution or through [www.cdnpay.ca](http://www.cdnpay.ca). If you have any questions about withdrawals from your bank account, contact us at 1-877-COVER ME® (1-877-268-3763), [www.coverme.com](http://www.coverme.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](http://www.cdnpay.ca).

Name of Account holder \_\_\_\_\_ Signature of Account holder \_\_\_\_\_

Second signature if joint account \_\_\_\_\_ Dated \_\_\_\_\_  
dd/mm/yyyy

**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

**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 \_\_\_\_\_ Dated \_\_\_\_\_  
dd/mm/yyyy

Signature of Co-Applicant \_\_\_\_\_ Dated \_\_\_\_\_  
dd/mm/yyyy

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