

**FollowMe™ Health**

# Application for FollowMe™ Health Insurance (The McLennan Group)

All applicants must complete Parts A, B, C and D. All applicants must complete and sign Applicant's Authorization and Declaration.

All applicants must have coverage under a Canadian provincial/territorial health care 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.

When you apply for insurance, your beneficiary is set as your estate. To change this, please log into SecureServe at [manulife.ca/secureserve](http://manulife.ca/secureserve).

## Part A – General Information

### Primary Applicant

Last Name	First Name	Initial		
Does each applicant have provincial/territorial health care coverage?    Yes    No				
Home Address	Unit/Apt.	City	Province	Postal Code
Home Telephone	Office Telephone			
Email (optional)				
If additional information is required, how may we contact you?	Home	Office	Email	

### Co-Applicant

Last Name	First Name	
Telephone	Email (optional)	
If additional information is required, how may we contact you?	Telephone	Email

Are you now covered by or did you recently have employer group health insurance coverage?    Yes    No  
 If yes, please indicate:

### Primary Applicant

Group Plan Number	ID Number	
Insurance Company	Date Benefits Ended	DD/MM/YYYY

### Co-Applicant

Group Plan Number	ID Number	
Insurance Company	Date Benefits Ended	DD/MM/YYYY

**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 provincial health card and be registered under the RAMQ Prescription Drug Insurance Plan, or have equivalent coverage under a group plan.

## Part B – Plan Choice

I/We apply for FollowMe™ Health:

Basic                      Enhanced  
 Enhanced Plus        Premiere

## Part C – Individuals to be Covered

Last Name	First Name	Code	Sex	Birth date DD/MM/YYYY	Age	Smoker? No. of Cigarettes Daily	Height inch/cm	Weight lbs/kg	Weight change in last year		Reason for weight change
									gain	loss	
Applicant		00									
Co-applicant		01									
Dependant		02									
Dependant		02									
Dependant		02									
Dependant		02									

If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

## Part D – Payment Options

**Initial Payment:** I/We hereby authorize Manulife to debit the initial two (2) months' premium, \$ \_\_\_\_\_, using my/our: \_\_\_\_\_  
Pre-Authorized Debit (PAD)

**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. To apply securely using your credit card, contact our licensed insurance advisors at **1 877 551-5566**.

**Subsequent payments** will be made by:

Option #1 Pre-Authorized Debit (PAD)  
PAD Billing Frequency: Monthly Semi-Annual (2% savings) Annual (4% savings)

**Important: For verification purposes, we require a sample cheque marked 'VOID'.**

Option #2 Direct Billing  
Direct Billing Frequency: Semi-Annual (2% savings) Annual (4% savings)

### Pre-Authorized Debit (PAD) Payment Information & Payment Authorization

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 \_\_\_\_\_

Transit Number \_\_\_\_\_ Institution Number \_\_\_\_\_ Bank Account Number \_\_\_\_\_

Financial Institution \_\_\_\_\_ Address of Account Holder \_\_\_\_\_

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 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 for 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 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 Payments Canada 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](http://www.payments.ca). If you have any questions about withdrawals from your bank account, contact us at 1-877-551-5566 or [more\\_info@manulife.ca](mailto:more_info@manulife.ca), or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, ON 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](http://www.payments.ca).

Signature of Account Holder \_\_\_\_\_ Dated DD/MM/YYYY

Second Signature if Joint Account \_\_\_\_\_ Dated DD/MM/YYYY

Account Holder Address (if different from Applicant) \_\_\_\_\_

## Personal Information Statement

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](http://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, 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 facilities
  - 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 1-877-551-5566, 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**  
**P.O. Box 1602**  
**500 King Street North**  
**Waterloo, ON N2J 4C6**

[Privacy\\_office\\_canadian\\_division@manulife.com](mailto: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.

## 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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with Manulife's Personal Information Statement. I/We understand and agree that coverage shall not become effective until the first of the month following final approval and receipt of the first premium payment.

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

Signature of Applicant \_\_\_\_\_ Signed at \_\_\_\_\_ City, Province \_\_\_\_\_ Date DD/MM/YYYY

Signature of Co-Applicant \_\_\_\_\_ Signed at \_\_\_\_\_ City, Province \_\_\_\_\_ Date DD/MM/YYYY

### Questions?

Contact Manulife toll-free at **1 877 551-5566**

Monday to Friday, 8 a.m. to 8 p.m.

or email **am\_info@manulife.com**.

Mail your completed application to Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.



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Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

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