

## FollowMe™ Life Insurance

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

### Section 1: Applicant Information

|   |                  |                                 |          |             |
|---|------------------|---------------------------------|----------|-------------|
| Last Name                               | First Name       | Initial                         | Male     | Female      |
| Home Address                            | Unit/Apt.        | City                            | Province | Postal Code |
| Date of Birth <small>DD/MM/YYYY</small> | Age              | I confirm my smoking status as: | Smoker   | Non-Smoker* |
| Home Telephone                          | Office Telephone |                                 |          |             |

### Spouse Information (if applying for Spouse coverage)


|   |                  |                                 |          |             |
|---|------------------|---------------------------------|----------|-------------|
| Last Name                               | First Name       | Initial                         | Male     | Female      |
| Home Address                            | Unit/Apt.        | City                            | Province | Postal Code |
| Date of Birth <small>DD/MM/YYYY</small> | Age              | I confirm my smoking status as: | Smoker   | Non-Smoker* |
| Home Telephone                          | Office Telephone |                                 |          |             |

\*Non-smoker status applies to people who have not used tobacco, tobacco cessation products including e-cigarettes or vaping products in the past 12 months. Smoker status is determined when your coverage is approved.


### Section 2: Amount of Insurance Applying for

I am applying for FollowMe™ Life coverage:

#### Applicant

Please indicate amount you're applying for:  \$  
Available from \$25,000 to \$200,000.

#### Spouse

Please indicate amount you're applying for:  \$  
Available from \$25,000 to \$200,000.

You are eligible to apply for FollowMe Life coverage equal to or less than your group life coverage amount.

### Applicant: Existing Coverage

Please provide information about your current or recently ended group life plan:

|                   |                                  |   |
|-------------------|----------------------------------|---|
| Employer Name     | Life Benefit Amount              | Date Benefits End(ed) <small>DD/MM/YYYY</small> |
| Insurance Company | Group and Identification Numbers |   |

Do you intend to replace any existing life insurance coverage (other than the coverage you had through an employer group benefits plan) with this insurance coverage?    Yes    No

If yes, please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us. We may not be able to issue an insurance policy if replacement is indicated.

### Spouse: Existing Coverage

Please provide information about your current or recently ended group life plan:

|                   |                                  |   |
|-------------------|----------------------------------|---|
| Employer Name     | Life Benefit Amount              | Date Benefits End(ed) <small>DD/MM/YYYY</small> |
| Insurance Company | Group and Identification Numbers |   |

Do you intend to replace any existing life insurance coverage (other than the coverage you had through an employer group benefits plan) with this insurance coverage?    Yes    No

If yes, please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us. We may not be able to issue an insurance policy if replacement is indicated.

### Section 3: Beneficiary Information

#### Applicant Beneficiary(ies):

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

- |                                    |              |
|------------------------------------|--------------|
| 1. Last Name                       | First Name   |
| Relationship to you, the applicant | % of Benefit |
| 2. Last Name                       | First Name   |
| Relationship to you, the applicant | % of Benefit |

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

#### Trustee:

- |                                 |              |
|---------------------------------|--------------|
| 1. Last Name                    | First Name   |
| Relationship to the beneficiary | % of Benefit |

#### For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. 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.

#### Spouse Beneficiary(ies):

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

- |                        |              |
|------------------------|--------------|
| 1. Last Name           | First Name   |
| Relationship to spouse | % of Benefit |
| 2. Last Name           | First Name   |
| Relationship to spouse | % of Benefit |

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

#### Trustee:

- |                                 |              |
|---------------------------------|--------------|
| 1. Last Name                    | First Name   |
| Relationship to the beneficiary | % of Benefit |

#### For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. 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.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

## Section 4: Payment Information

I/We hereby authorize Manulife to debit the initial premium, \$ \_\_\_\_\_, and subsequent premiums, from my/our:

**Pre-Authorized Debit (PAD) – monthly**

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

For your convenience, if you choose payment by pre-authorized debit or credit card, your future premium billings will automatically reflect the same payment method.

### Payment Information

#### Section A: For pre-authorized debit (PAD) payment option

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.

#### Payment authorization for pre-authorized debit (PAD) payment options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account on the day on which insurance premiums are due 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 10 days 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 1 800 396-4389 or [am\\_info@manulife.com](mailto:am_info@manulife.com), 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).

Name of Account Holder \_\_\_\_\_ Signature of Account Holder \_\_\_\_\_

Second signature if joint account \_\_\_\_\_ Dated \_\_\_\_\_ DD/MM/YYYY

Account holder address (if different than 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 1 800 396-4389, 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.

**Declaration and Authorization** – Please read carefully before signing.

I/We, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company. I/We declare that the statements contained in this application 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 understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date is a risk not covered. I/We have read and understand that there are exclusions and limitations on the coverage applied for, including an exclusion for pre-existing conditions. I/We understand that insurance will take effect on the date my/our properly completed application and the first premium are received by Manulife, subject to approval of the company’s underwriters.

Relative to the insurance applied for, I/we, the undersigned person to be insured, hereby authorize any **licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB Inc., the group policy administrator, the insurance plan sponsor**, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person/people that has any records or knowledge of me/us or my/our health to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

I/We authorize Manulife to consult its existing files for this purpose. I/We authorize Manulife to hold a personal file about myself/us and my/our insurance coverage.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death.

I/We have read, understand and agree to the Personal Information Statement.

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 Spouse \_\_\_\_\_ Signed at \_\_\_\_\_ City, Province \_\_\_\_\_ Date DD/MM/YYYY

Please send the completed application to: **Regular Mail:**  
Manulife  
P.O. Box 670  
Stn Waterloo  
Waterloo, ON N2J 4B8

**Courier:**  
Manulife  
500 King Street  
Affinity Markets New Business  
Delivery Station 500-GB  
Waterloo, ON N2J 4C6

If you have any questions about this application, please call **1.866.795.7285**



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