

FollowMe™ Plan Application



Membership Number _____
 Centre _____
 Agent ID **IM000**
 Logo ID _____

Part A — General Information

Applicant's Last Name _____ First Name _____ Initial _____ Health Card Number: _____

Apt. Number, Street Number & Name _____ Marital Status: Single Married Other

City or Town _____ Province _____ Postal Code _____ Occupation: _____

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

Home Telephone: _____ Office Telephone: _____

E-Mail: _____

Please provide us with information on your current group health plan:

Employer Name _____ Insurance Company _____

Coverage to be Replaced _____ Date Benefits End DD / MM / YYYY

Group and Identification Numbers _____

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):

Name _____ Relationship to Applicant _____

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

Part B — Plan Choice

I/We apply for: FollowMe Basic FollowMe Enhanced FollowMe Enhanced Plus FollowMe Premiere

Part C — Individuals to be covered

First Name	Last Name	Health Card No.	Code	Sex	Birth Date DD/MM/YYYY	Age
A P P L I C A N T		_____	00		____ ____	
C O - A P P L I C A N T		_____	01		____ ____	
D E P E N D A N T C H I L D		_____	02		____ ____	
D E P E N D A N T C H I L D		_____	02		____ ____	
D E P E N D A N T C H I L D		_____	02		____ ____	

Part D — Billing Options

INITIAL PAYMENT: I 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 (PAP) Plan from my Financial Services Account (please complete Part E below)

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

Credit Card: (Please also complete Part E below)

Visa Mastercard Amex Account Number _____ Expiry Date ____/____/____

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 NSF fee will be charged for all NSF transactions.

Part E — Financial Institution

Name of the account holder (if other than 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 the authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payment 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 Applicant _____ Second Signature if Joint Account _____

Part F — 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. 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

Signature of Co-Applicant

Date