Manulife Financial

Group Benefits
Personal Critical Illness Payment Information

Premium amount(s) are specified in your contract and may change over time. Please ensure funds are available in your account at the time of the application as your premium is due the 1st of the month following approval. If more than one month of premium is due that amount will be withdrawn from your account.

For Manulife Financial use

Policy number(s)	Certificate number

Plan member name (first, middle initial, last)

1 Monthly payment options

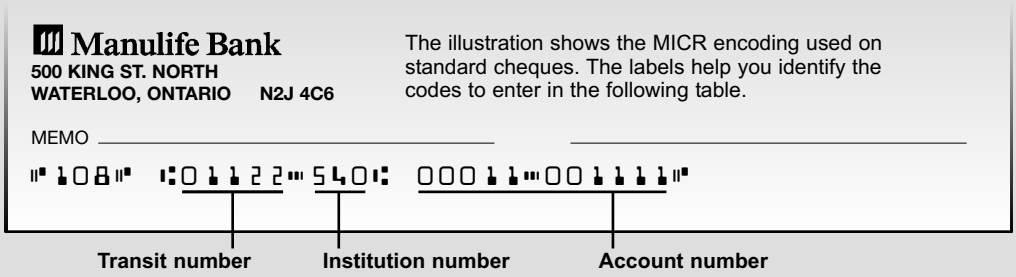
Please complete section 1a for Pre-Authorized Debit or 1b for credit card payment.

a) For Pre-Authorized Debit (PAD)

For verification purposes we require a VOID cheque if a payment is being withdrawn from your financial institution.

Select one of the following:

◯ Personal PAD ◯ Business PAD



Name of account holder

Name of financial institution	Type of account
	◯ Chequing ◯ Non-chequing

Transit number	Institution number	Account number

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 on page 8 of 9.

Non-chequing accounts: For accounts with no chequing privileges, Manulife Financial requires validation from your financial institution (e.g. withdrawal slip with official stamp) in order to begin the pre-authorized payment process.

b) For credit card payment

Name of account holder (if other than plan member)

Credit card	Account number	Expiry date (mm/yy)
◯ Visa ◯ MasterCard ◯ Amex		

Manulife Financial

Group Benefits
Personal Critical Illness Certification and Authorization

1 Certification and authorization

I certify that I, being the plan member with the capacity to contract, am applying for this personal benefits coverage/insurance ("Coverage") and that all information provided in support of this application is true and complete. **I agree** that my Coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in support of this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information and personal health information including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, relevant to this application ("Information") for the purposes of the assessment, investigation and/or management of this application, including but not limited to medical underwriting; and where Coverage is issued, the administration, audit and management of my Coverage and the investigation of any claims made thereunder, including my participation in any independent medical assessments (collectively, the "Purposes"). **I understand** that I am responsible for any fees related to the completion of this application. Where this application pertains to one of my Dependents (spouse and/or child) **I certify that I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any such Dependants, for the Purposes. **I authorize** any person or organization with Information including, but not limited to, any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I hereby authorize** the use of my Social Insurance Number ("SIN"), where my SIN is used as my certificate number, for the purposes of identification and administration of this application and any Coverage, and for the facilitation of any pre-authorized collection and credit card billing.

I authorize Manulife to withdraw, until further written notice from me or my duly authorized representative, all premium payments ("Payments") due in relation to the Coverage, either from the bank account identified on the attached void cheque, or from the credit card account I have identified in this application (both referred to herein as the "Account"), whichever is applicable, on or about the first business day of each month in which Coverage premiums are due. **I also understand and agree** that either Manulife or I may, at any time upon written notice, discontinue the direct withdrawal of Payment(s), from my Account, in which case Manulife shall be entitled to require another method of payment, acceptable to Manulife. The terms and conditions of this pre-authorized collection and credit card billing authorization shall apply to the Accounts herein named by me and any other Accounts I choose to name in the future, and shall remain valid for the duration of my Coverage or until revoked by me in writing. **I agree** that if I have asked Manulife to debit my bank account for a Pre-authorized Debit (PAD) plan (Funds Transfer PAD), **I authorize** the bank or other financial institution I have named to honour my instructions. **I understand** that Manulife or I may terminate a PAD plan by giving 10 days written notice, beginning on the date the notice is mailed. **I understand** that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights or cancellation rights, I may contact Manulife or visit www.cdnpay.ca for more information.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not yet guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive Information (or other materials related Manulife products and services) from Manulife through the email address identified on this form that I may contact the Customer Service Centre to opt-out of receiving this information.

I agree a photocopy or electronic version of this authorization is valid. **I acknowledge** that Manulife's Privacy Policy is available upon request or at www.manulife.ca

Signature of plan member	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if the Evidence of Insurability has been completed on behalf of the spouse)	Date signed (dd/mmm/yyyy)
Signature of account holder, if different from plan member	Date signed (dd/mmm/yyyy)
Signature of joint account holder (if applicable)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a personal benefits file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

Please complete next page.

2 Mailing instructions

We require a VOID cheque if payment is being withdrawn from your financial institution.

Please send the completed form to:

Plan Member Administration
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1