Manulife Financial

Group Benefits

◯ Request for Over-Age Dependent Coverage (Complete sections 1, 2 (if applicable), 3 and 5)

◯ Termination of Over-Age Dependent Coverage (Complete sections 1, 4 and 5)

Please complete form and send to: Manulife Financial, P.O. Box 1627, Waterloo, Ontario N2J 4P4

1 General information

Plan sponsor name	Plan number(s)		Plan member ID
Last name of plan member	First name		Middle initial
Address of plan member	City	Province	Postal code

Last name of dependent	First name	Relationship to plan member	Dependent's date of birth (dd/mmm/yyyy)	Sex ◯ Male ◯ Female
Address of dependent	City	Province	Postal code	

2 Disabled dependent information

If you are completing this section of the form, **please attach a report or letter from the dependent's personal physician** confirming the diagnosis and prognosis for the dependent, and the extent to which the physician determines the dependent is unable to work.

Is the disabled dependent a resident of your home 365 days a year? ◯ Yes ◯ No
If "No", please explain.

Has the disabled dependent ever been employed? ◯ Yes ◯ No

If "Yes", please give most recent date of employment and description of type of employment.

Date (dd/mmm/yyyy)	Type of employment

Is disabled dependent eligible for: a) benefits under a government plan? ◯ Yes ◯ No
b) Health, Dental, Disability Benefits from another group plan? ◯ Yes ◯ No

If answering "Yes" to either of the above questions, please give complete details.

Are you the sole means of the disabled dependent's support? ◯ Yes ◯ No
If "No", please explain.

3 Full-time student

Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the next school year, the upper limit of the dependent definition age, or until coverage is terminated.

Name of accredited school/college/university		Location of school/college/university
Date school year:	Begins (dd/mmm/yyyy)	Ends (dd/mmm/yyyy)

4 Termination of over-age student coverage

This only applies if you have over-age dependent children who are no longer students.

◯ I wish to terminate ALL coverage for DEPENDENT NAME

Effective date of termination (dd/mmm/yyyy)

Reason for termination

5 Plan member signature

I certify that the information in this form is true and complete, to the best of my knowledge.
I authorize any health care provider, other insurance company, any type of workers' compensation board, my plan sponsor, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process this application.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:
- our employees and service representatives 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, if necessary, correct any inaccurate information.

Please sign here

Signature of plan member	Date signed (dd/mmm/yyyy)