

ENROLMENT FORM

Hospital Cash Insurance Plan



SELECT THE COVERAGE YOU WISH TO ENROL FOR

(check only one box below)

\$300.00 a day

\$200.00 a day

\$100.00 a day

Customer Only Coverage

Customer & Family Coverage

CUSTOMER — please complete to enrol for coverage

SPOUSE — please complete if enrolling for family coverage

CUSTOMER INFORMATION (please print)

SPOUSE INFORMATION (please print)

Name: _____

Name: _____

Address: _____

Address: _____
(if different than that of Customer)

City: _____

City: _____

Province: _____ Postal Code: _____

Province: _____ Postal Code: _____

Date of Birth: DD / MM / YYYY Male Female

Date of Birth: DD / MM / YYYY Male Female

Telephone: { _____ }
(best number to reach you at)

Telephone: { _____ }
(best number to reach you at)

E-mail: _____
(optional)

E-mail: _____
(optional)

METHOD OF PAYMENT

Select the payment method you prefer and provide details where requested (check only one box below)

By Credit Card Monthly:

VISA MasterCard

Card #: - - - Expiry Date: /

By Pre-Authorized Collections (PAC) Monthly:

Please enclose a sample cheque marked "VOID"

For your convenience, if you choose payment by Pre-Authorized Collections Plan or credit card, your future premium billings will automatically reflect the same payment method.

I authorize Manulife Financial ("the Company") to make a monthly withdrawal from the account described on the accompanying specimen cheque for monthly insurance premiums due on or after the date of this authorization. The Pre-Authorized Collections Plan may be terminated by either the Company or by me through written notice. The Company also reserves the option to change the method of payment for another qualifying mode after the occurrence of a deposit not honoured.

PLEASE COMPLETE BOTH SIDES →→→

