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

CUSTOMER INFORMATION (please print)

Name: ______________________________

Address: ______________________________

City: ______________________________

Province: ______________ Postal Code: ________

Date of Birth: DD / MM / YYYY ☐ Male ☐ Female

Telephone: ( ) ____________________
(best number to reach you at)

E-mail: ______________________________
(optional)

SPOUSE — please complete if enrolling for family coverage

SPOUSE INFORMATION (please print)

Name: ______________________________

Address: ______________________________
(if different than that of Customer)

City: ______________________________

Province: ______________ Postal Code: ________

Date of Birth: DD / MM / YYYY ☐ Male ☐ Female

Telephone: ( ) ____________________
(best number to reach you at)

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: M M / Y Y

By Pre-Authorized Debit (PAD) Monthly:

☐ Please enclose 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.

PLEASE COMPLETE BOTH SIDES →→→

PAYMENT INFORMATION

For Pre-Authorized Debit (PAD) payment options

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 Credit Card payment 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 through written notice. 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.

Name of Cardholder ______________________________ Signature of Cardholder __________________

Second Signature If Joint Credit Card Account__________________ Dated DD / MM / YYYY

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife Financial to withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date I/we sign this authorization. I/We understand that except for the initial premium, which is due with this application, subsequent premiums will be withdrawn on the first business day of the month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with the insurance contract and as required to administer the policy; **I/we waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If my/our bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife Financial may attempt to withdraw that payment again within 30 days. Manulife Financial reserves the right to ask me/us for an alternate method of payment if my/our payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. Premium amounts may change in accordance with my/our insurance contract. I/We and/or Manulife Financial can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Manulife Financial receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through HYPERLINK "http://www.cdnpay.ca" www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-866-693-7150, HYPERLINK "mailto:am_service@manulife.com" am_service@manulife.com or write to us at Manulife Financial, PO Box 188, Stn Place-d'Armes, Montreal QC H2Y 9Z9.

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, you may contact your financial institution or visit HYPERLINK "http://www.cdnpay.ca" www.cdnpay.ca.

Name of Account Holder ____________________________ Signature of Account Holder ________________

Second Signature If Joint Account __________________________ Dated DD / MM / YYYY

Account Holder Address (if different from Applicant) ______________________________________

PLEASE COMPLETE BOTH SIDES →→→

TERMS AND CONDITIONS — Please read carefully before signing.

Declaration. I, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company ("Manulife Financial"). I declare that the statements contained in this application are true and complete and together with any other forms signed by me in connection with this application, form the basis for any policy issued hereunder. I 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 understand that there are exclusions and limitations on the coverage applied for. I understand that insurance will take effect on the first of the month following the date on the application and provided payment of the first premium is received by Manulife Financial at its office.

Authorization. I, the undersigned applicant(s), authorize Manulife Financial, its subsidiaries, affiliates and agents, to use the information in this application and its existing files to offer me their products or services. I understand and agree that from time to time, Manulife Financial may share product status information with Laurentian Bank of Canada for the purpose of general marketing statistical analysis. I understand that my consent to the use of such information to offer me products and services is optional and that, if I wish to discontinue such use, I may write to Manulife Financial at the address shown on this document. A photocopy or facsimile of this authorization shall be as valid as the original.

Notice On Privacy And Confidentiality. The specific and detailed information requested on the Enrolment Form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Further, your consent to the use of personal information to offer you products and services is optional, and if you wish to discontinue such use you may write to Manulife Financial at the address shown below. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn. A, Toronto, Ontario M5W 5M3.

Important: This product is not intended as replacement insurance for any life insurance you may have. Please do not cancel your existing coverage.

Customer's Signature: X ______________________ **Date:** DD / MM / YYYY
(if enrolling for coverage)

Spouse's Signature: X ______________________ **Date:** DD / MM / YYYY
(if enrolling for coverage)

Questions? Call us at 1-866-693-7150

Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time

Manulife Financial, PO Box 188, Stn Place-d'Armes, Montreal QC H2Y 9Z9

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