London Health Sciences Centre

Group Benefit Application

EFFECTIVE DATE: M M D D Y Y

PART 1: EMPLOYEE INFORMATION

Employee Last Name	First Name	Middle Initial	
Group Number Account/Div # 86936/005/F	Employee ID (Do not have to complete)	Sex ☐ Male ☐ Female	Date of Birth M M D D Y Y

PART 2: GROUP BENEFIT COVERAGE INFORMATION

I wish to **enroll**:	☐ **Extended Health:** ☐ Single ☐ Family ☐ **Dental:** ☐ Single ☐ Family
I wish to **waive:**	☐ **Extended Health** ☐ **Dental**

Does your spouse have coverage through another plan? ☐ Yes ☐ No
If Yes, does the spousal plan cover the following: ☐ Single ☐ Family
If Family, does the spousal plan cover the following: Employee (Resident): ☐ Extended Health ☐ Dental
Child(ren): ☐ Extended Health ☐ Dental

Name of Carrier of Spouse's Plan:	Plan/Group Number	Plan Member ID (Certificate No.)	Effective Date M M D D Y Y

PART 3: DEPENDENT INFORMATION

For each dependent, including spouse, please provide the following information

*****Common Law Status – Must have been co-habitating for a period of one (1) year.*****

☐ Add ☐ Delete	**Dependent's Name** (Last, First):	**Relationship:** ☐ Spouse ☐ Child ☐ Common Law **Gender:** ☐ M ☐ F **Date of Birth:** M M D D Y Y
☐ Add ☐ Delete	**Dependent's Name** (Last, First):	**Relationship:** ☐ Spouse ☐ Child ☐ Common Law **Gender:** ☐ M ☐ F **Date of Birth:** M M D D Y Y
☐ Add ☐ Delete	**Dependent's Name** (Last, First):	**Relationship:** ☐ Spouse ☐ Child ☐ Common Law **Gender:** ☐ M ☐ F **Date of Birth:** M M D D Y Y
☐ Add ☐ Delete	**Dependent's Name** (Last, First):	**Relationship:** ☐ Spouse ☐ Child ☐ Common Law **Gender:** ☐ M ☐ F **Date of Birth:** M M D D Y Y

PART 4: CERTIFICATION AND AUTHORIZATION

I certify that all the information in this form is complete, current and accurate to the best of my knowledge and belief and that I have authority to release and exchange personal information concerning my spouse and my dependent. I understand that this information will be maintained in a HEALTH file with Manulife Financial. I understand that persons, with satisfactory identification and proof of entitlement, will have the right to request access and, if necessary, rectify such personal information. I understand that this information Manulife employees, its reinsurers, their representatives in the performance of their duties, people to who access has been granted or those authorized by law will have access to information maintained in file. In applying for the Group Benefits for which I am, or may become eligible, I authorize my employer to make deductions from my pay.

Plan Member's Signature:_______________________________________ **Date Signed:** M M D D Y Y

PART 5: HUMAN RESOURCES USE ONLY

Benefit Program	Manulife Division	Code
Date Entered in LHSC (MM/DD/YY)	Date Entered in Manulife (MM/DD/YY)	