RE/MAX All Stars Inc. Health Benefit Plan Application

*** All applicants must complete parts A, B, C and D**
*** All applicants must complete and sign Applicant's Declaration on page 2**

AIR MILES® # 8

For Manulife Financial Use Only
keyed ______________
Approval ______________

Agent ID: 0N2169

Logo ID

PART A • General Information

Applicant's Last Name ________________________ First Name ______________________ Initial _______ Government Health Card Number

Apt. Number _________________ Street Number and Name ______________________________________ Home Telephone (_____) ______ - ___________

City or Town ___________________________ Province _________________________ Postal Code ______________________ Occupation _______________________

Marital Status ❑ Single ❑ Married ❑ Other ___________________________

Applicant's Office Telephone (_____) ______ - ___________ Co-Applicant's Office Telephone (_____) ______ - ___________

Applicant's Fax (_____) ______ - _________ Co-Applicant's Fax (_____) ______ - _________

Applicant's E-mail (_____) ______ - _________ Co-Applicant's E-mail (_____) ______ - _________

If additional information is required during regular business hours, how may we contact you? ❑ Home ❑ Office ❑ E-mail

Are you now covered or did you have previous health insurance coverage with Manulife Financial or any other insurance company? ❑ Yes ❑ No

If "Yes" please indicate:

Plan Number ____________________ ID Number ____________________ Insurance Company _______________________ Date Benefits Ended _____ / _____ / ________ (dd mm yyyy)

Plan Number ____________________ ID Number ____________________ Insurance Company _______________________ Date Benefits Ended _____ / _____ / ________ (dd mm yyyy)

Is this application intended to replace your current coverage? ❑ Yes ❑ No

Beneficiary designation for payment of Accidental Death & Dismemberment Benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate)

Name ____ Relationship to Applicant ____________________________

Signature of Applicant ____ Dated _____ / _____ / ________ (dd mm yyyy)

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed

Name of Trustee ____ Relationship to Applicant ____________________________

Signature of Applicant ____ Dated _____ / _____ / ________ (dd mm yyyy)

PART B • Plan Choice

I/We are applying for: ❑ Bronze Health & Dental Plan

PART C • Individuals To Be Covered

First name / Last Name	Health Card Number	Code	Sex	Birth Date dd mm yyyy	Age	Smoker? Number of Cigarettes Daily	Height Feet' & Inches"	Weight Pounds or Kilograms	Weight change in Last Year gain loss	Reason
		00								
Applicant		01								
Co-Applicant		02								
Dependent Child		02								
Dependent Child		02								
Dependent Child		02								

Dependent Child

PART D • Billing Options

Initial Payment: I hereby authorize McGill Financial to debit the initial 2 months premium, $ ______________________ , from my:

❑ Financial Institution Account ❑ Credit Card Account

Subsequent Payments: Will be made by:

❑ Pre-Authorized Payment Plan (PAP) From My financial Institution Account (Please also complete **Part E** below)

❑ Credit Card (Please also complete **Part E** below): ❑ Visa ❑ MasterCard ❑ Amex Account # ____ Expiry Date ___________________

Cardholder ____ Signature of Cardholder ____
(If other than Applicant or Co-Applicant)

PAP/Credit Card Billing Frequency: ❑ Monthly ❑ Semi-annually ❑ Annually

❑ **Direct Billing: Direct Billing Frequency:** ❑ Semi-annually ❑ Annually

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

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. A $25 NSF fee will be charged for all NSF transactions.

PART E • Financial Institution • For Pre-Authorized Payment Plan

Name of account holder(s) if different from Applicant ____

Financial Institution ____

Address ____ City/Town ____

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 payment 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. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

For Pre-Authorized payment and Credit Card billing 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/us through written notice.

____ ____
Signature of account holder Second signature if joint account

If you require more space to complete any part of this application, please attach a separate sheet.

Applicant's Declaration • All Applicants Must Complete This Section

This plan is underwritten by The Manufacturers Life Insurance Company.

❑ Check here if you do not wish to receive further information and material on Manulife Financial's products.

I/We hereby acknowledge that the statements contained herein are true and complete and together with any other forms signed by me/us in connection with this application form the basis for any policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife Financial reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality and the Notice on Information Provided to the AIR MILES® Reward Program. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

____ ____ Dated _____ / _____ / ________
Signature of Applicant Signature of Co-Applicant dd mm yyyy

This Plan is offered through Manulife Financial (The Manufacturers Life Insurance Company).
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