

Please complete this section if you have applied for dependent coverage.

	Name(s)			Sex	Date of Birth	Full-time Student	Disabled
	First	Initial	Last	M/F	mm/dd/yyyy	✓	✓
Spouse							
Child							
Child							
Child							
Child							

Is your spouse presently covered under another insurance plan? Yes No

If yes, please provide: _____
 Name of insurance company Policy number

- I authorize my Employer to make the appropriate payroll deductions.
- I understand that satisfactory evidence of insurability must be provided by myself or my spouse to become eligible for Optional Employee/Spouse Life Insurance benefit.
- I understand that on the date my insurance becomes effective with Manulife Financial that I must be actively-at-work. I also understand that on the date my dependent's insurance becomes effective with Manulife Financial that they cannot be confined to home or hospital.
- I authorize WEBS and Manulife Financial to collect, use and disclose personal information concerning me and/or my dependent(s) (where applicable) for the purpose of determining eligibility for Manulife products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca or by request.

X _____
 Signature of Employee Date

For Office Use Only

Title: _____
 Employment Date: _____
 Rate of Pay: _____
 Cost Centre: _____
 Payroll Number: _____