

## Coverage After Release (CAR)/ Insurance for Released Members (IRM) Exclusive Options Form Group Policy # 901102

## **Manulife Financial**

1. MEMBER INFORMATION								
Service Number (SN) Ra	nk Surname			First Name		Initials		
					( )			
Mailing Address					Home Phone	:#		
					( )			
PO Box, Rural Route, etc.					(circle) work/	cell phone/pager #		
City		Prov	. Postal Co	de	Email Addres	SS		
2. SPOUSAL INFORMATION								
Surname of Spouse or Former Spouse		First N	ame			Initials		
3. OPTION 1 — STAY IN CAR PLAN								
I elect to remain insured under the Coverage After Release Plan. I do not wish to transfer any portion of my existing CAR coverage to IRM.								
acknowledge that the premium rates under the	: Coverage After Release	e plan ch	anged effective March	1 1, 2006.				
Member's Signature			Month Year					
		Day						
4. OPTION 2 & 3 — JOIN IRM PLAN OF	R TRANSFER ONLY A P	ORTION						
Insured Member — Transfer Full Ame	ount:		Insured Spouse	— Transfer	Full Amou	nt:		
or Transfer Partial Amo	ount:		or Transfer Partial Amount:					
If you are transferring any or all of your coverage to IBM you must complete the Population Population February The hearficing disc) for any CAD and C								
If you are transferring any or all of your coverage to IRM, you <u>must</u> complete the Beneficiary Designation below. The beneficiary(ies) for any CAR coverage not transferred to IRM will remain the same.								
5. MEMBER COVERAGE—BENEFICIA	RY DESIGNATION							
As the certificate holder, I hereby designate the following beneficiary(ies) for my IRM coverage. This beneficiary designation is revocable unless stated otherwise.								
Note: The designation of a spouse as beneficiary for Life Insurance by a member who became a participant while residing in the Province of Quebec, may be irrevocable if the member did not specify it to be revocable. In such a case a change of beneficiary cannot be made without the spouse's written permission. If you know this to be relevant in your								
case, please have your spouse sign Block 7 "Relea	rsons or Institutions	Relation	ship to Certificate Holder	If Minors, Dat	e of Birth *	Percentage of Proceeds		
Primary			•	Day/Mont		(Indicate if Equal Shares) %		
Primary						% %		
Primary						%		
In the event of death of the Primary Beneficiary(ies):					-			
Name (in full) of Per		Relati	onship to Certificate Holder	If Minors, Date Day/Mont		Percentage of Proceeds (Indicate if Equal Shares)		
Contingent			110.000	<i>Day</i> , mom	.,, 104.	%		
Contingent						%		
Contingent Contingent			+			% %		
*With respect to the minor child(ren) designated above, I appoint the following as trustee(s) to receive any proceeds under my plan. Please provide the name, relationship, current address and phone number of the trustee(s). If this does not apply, please indicate n/a.								
TRUSTEE(S):								

	PR	OTECTED B (when completed)							
		Service Number (SN):	Service Number (SN):						
6. SPOUSAL COVERAGE—BENEFICIARY DESIGNATION Contingents & Trustee(s) same as member, or									
As the certificate holder, I hereby designate the following beneficiary(ies) for my IRM coverage. This beneficiary designation is revocable unless stated otherwise.									
	Name (in full) of Persons or Institutions	Relationship to Certificate Holder	If Minors, Date of Birth * Day/Month/Year	Percentage of Proceeds (Indicate if Equal Shares)					
Primary	Always the member unless named otherwise	Member		100 %					
In the event of death	of the Primary Beneficiary(ies):								
	Name (in full) of Persons or Institutions	Relationship to Certificate Holder	If Minors, Date of Birth*	Percentage of Proceeds					
Contingent			Day/Month/Year	(Indicate if Equal Shares) %					
Contingent				%					
Contingent				%					
TRUSTEE(S):									
7. RELEASE	OF BENEFICIARY (Please see note in Bloo	ck 5)							
	peing the present beneficiary for the life insura		er Policy No. 901102, hereb	v relinguishes all rights, title, and					
	ary for that portion of the coverage the membe			, remiquierios am riginio, amo, ama					
Dated at		thisday of	, 20						
	Location		Month						
	Witness	Benef	ficiary						
,									
8. SIGNATURE									
Declaration and Authorization by Applicant									
I hereby elect to transfer the portion of my current Coverage After Release (CAR) life insurance, as indicated in Block 4, to the Insurance for Released Members (IRM) Plan. In doing so, I understand that the amount of CAR coverage I have elected to transfer as of the date this form is signed will continue in force under the IRM Plan unless subsequently modified by me. I also understand that there are no Waiver of Premium Benefits and no Paid Up Certificates available or issued under the IRM Plan, and as such, any claim I may have had for either Waiver of Premium Benefits or a Paid Up Certificate under the portion of CAR coverage I am electing to transfer, will cease to exist on the date this form is received. I also understand that, where I elect to maintain coverage on an insured person for the maximum duration under the IRM Plan, such coverage will terminate automatically on the insured person's seventy-fifth (75 <sup>th</sup> ) birthday.  I certify that all information I have provided in this form is true and complete. I authorize Manulife Financial ("Manulife"), its reinsurers as necessary, and SISIP Financial Services (SISIP FS) to collect, use, maintain and disclose personal information (collectively) "Information" relevant to this insurance coverage									
for the purposes o coverage (collective providers, profession	f Group Insurance plan administration, underw rely) the "Purposes". <b>I authorize</b> any person o onal regulatory bodies, any employer, group p use, maintain and exchange this Information of the control o	riting, audit and the assessment, in or organization with Information, inc lan administrators, insurers, invest	nvestigation and management cluding any medical and heal digative agency and any adm	nt of any claim under this th professionals, facilities or inistrators of other benefits					
Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Insurance plan health file. Access to your information will be limited to:  > Manulife employees, representatives, reinsurers, service providers and SISIP FS in the performance of their jobs;									
<ul> <li>Persons to whom you have granted access; and</li> <li>Persons authorized by law.</li> <li>The information provided on this form is protected from unauthorized disclosure under Canada's <i>Privacy Act</i>. You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.</li> </ul>									
Member's Signa	ture Day Month	Year Spouse's Signatur	re	Day Month Year					
Please return co	mpleted form to: Manulife Financial, SI	SIP Services, 2727 Joseph Hov	we Drive. PO Box 1030 H	alifax. NS R31 2X5					
		52. 36. 11663, 2727 3036pit 110V	Dilve, 10 Dox 1030, 11	amany 110 D33 Z/13					
Manulife Financial	Office Use Only								

## PROTECTED B (when completed)

Verified by:

Day

Month

Year