

Affinity Markets - Policy Services Change of information

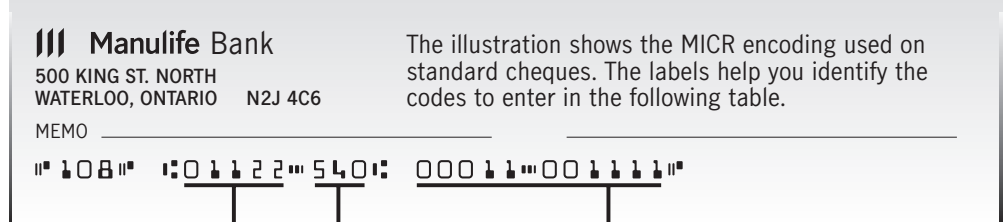
- To be completed by the insured person unless otherwise indicated.
- Please retain copies for your files as originals will not be returned.

1 Insured person information	Policy/Plan/Certificate number		Identification number (Only complete for Health and Dental Policies)		
	Name of insured person			Email	
	Address of insured person (number, street and apartment)				Phone number
	City/Town	Province/State	Country	Postal code/Zip code	
Type of change	<input type="radio"/> Name change <input type="radio"/> Address/Email change <input type="radio"/> Payment information change				
2 Name change	<p>Submit the appropriate legal documents if:</p> <ul style="list-style-type: none"> • the given name or surname has changed for reasons other than marriage, divorce or adoption • a company has changed its name. <p>Examples:</p> <ul style="list-style-type: none"> • Certificate of Amendment • Supplementary Letters Patent <p>No documentation is required if the name changed due to marriage, divorce or adoption.</p>				
3 Address/Email change	The Manufacturers Life Insurance Company is being requested to change the name of the				
	<input type="radio"/> Insured person <input type="radio"/> Policy Owner				
	From				
	To				
	Reason for change		Date of change (dd/mmm/yyyy)		
	<input type="radio"/> Marriage <input type="radio"/> Divorce <input type="radio"/> Adoption <input type="radio"/> Other _____				
Indicate your previous address/email and your new address/email for the Policy/Certificate number set out in Section 1. The changes will be effective on the date it is received and accepted by us.	Previous address (number, street and apartment)				
	City/Town	Province/State	Country	Postal code/Zip code	
	New address (number, street and apartment)				
	City/Town	Province/State	Country	Postal code/Zip code	
	Previous phone number		New phone number		
	Previous email		New email		
4 Your payment method	<input type="radio"/> Option 1 – Payment by cheque (annual only) or pre-authorized debit Annually – Please enclose a cheque payable to Manulife and mail it along with this change of information form to the address in section 8. A \$25.00 fee may be charged for all NSF (Non-Sufficient Funds) transactions. Pre-Authorized Debit (PAD) – Please complete the payment information on the following page. Frequency: <input type="radio"/> Monthly <input type="radio"/> Annually <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly (Semi-Annual, Quarterly - only offered on Health and Dental policies)				
	OR <input type="radio"/> Option 2 – Credit card To add or change your credit card number, please call our Customer Service at 1-800-268-3763; Your expiry date will be updated automatically, no action is necessary.				

4 Your payment method (continued)

Pre-Authorized Debit (PAD) payment information

Enclose a cheque marked 'VOID'



Name of Account Holder			
Name of bank or financial institution	Transit number	Bank number	Account number
Address	City/Town	Province	Postal code

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: If a VOID cheque cannot be provided, please visit your financial institution to obtain a Confirmation of Banking Information Form.

Payment authorization

Please complete one option.

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife to make automatic withdrawals from my/our bank account on or about the first business day of the month in which insurance premiums is due on or after 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 10 days' 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 may attempt to withdraw that payment again within 30 days. Manulife 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 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 receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner. A \$25.00 fee may be charged for all NSF (Non-Sufficient Funds) transactions.

You may obtain a sample cancellation form by contacting your financial institution or through **payments.ca**. If you have any questions about withdrawals from your bank account, contact us at 1-877-598-2273, **am_service@manulife.ca** or write to us at Manulife, PO BOX 670, STN WATERLOO, WATERLOO ON N2J 4B8.

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 **payments.ca**.

Name of Account Holder	Signature of Account Holder
Second signature if joint account	Dated (dd/mmm/yyyy)
Account Holder address (if different from Applicant)	

<p>5 Declaration and Authorization</p> <p>Please sign here</p> <p>If owner is a corporation or other entity, we require signatures from duly appointed signing authorities, as authorized by a corporate resolution or similar document or the signature and declaration of the only person authorized to sign on behalf of the corporate or other entity.</p>	<p>By signing below you:</p> <ul style="list-style-type: none"> • are authorized to request the changes set out herein • authorize us to act on the changes set out on this form • consent to us accepting a fax or electronic version of this form. <table border="1" data-bbox="441 174 1555 512"> <tr> <td data-bbox="441 174 1192 258">Signature of insured person</td> <td data-bbox="1192 174 1555 258">Date signed (dd/mmm/yyyy)</td> </tr> <tr> <td data-bbox="441 258 1192 342">Signature of additional insured person (if applicable)</td> <td data-bbox="1192 258 1555 342">Date signed (dd/mmm/yyyy)</td> </tr> <tr> <td data-bbox="441 342 1192 426">Signature of owner (if other than insured person)</td> <td data-bbox="1192 342 1555 426">Date signed (dd/mmm/yyyy)</td> </tr> <tr> <td data-bbox="441 426 1192 512">Signature of owner (if other than insured person)</td> <td data-bbox="1192 426 1555 512">Date signed (dd/mmm/yyyy)</td> </tr> </table>	Signature of insured person	Date signed (dd/mmm/yyyy)	Signature of additional insured person (if applicable)	Date signed (dd/mmm/yyyy)	Signature of owner (if other than insured person)	Date signed (dd/mmm/yyyy)	Signature of owner (if other than insured person)	Date signed (dd/mmm/yyyy)
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<p>6 Statement of confidentiality</p>	<p>The specific and detailed information requested on this form is required to process your change request. To protect the confidentiality of this information, Manulife will establish a “financial services file” from which this information will be used to process this form, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators 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. 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 at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Customer Experience, Manulife, PO BOX 1602, DEL STN 500 - 4-A, WATERLOO ON N2J 4C6.</p> <p>A copy of our privacy principles and practices is available for viewing at manulife.ca.</p>								
<p>7 Accessibility at Manulife</p>	<p>Manulife is committed to offering products and services to persons with disabilities, in ways that are consistent with the principles of dignity, independence, integration and equal opportunity. Manulife has a core belief that everyone should be treated with courtesy and respect and made to feel welcome. Manulife's accessibility policy allows you to receive this form in alternate formats upon request. Please contact us at accessibility@manulife.ca, or call us at 1-855-891-8671, if you would prefer this document in an alternate format. If you would like more details about accessibility at Manulife, we would encourage you to visit our website at manulife.ca/accessibility.</p>								
<p>8 Mailing instructions</p>	<p>Manulife Attention: Affinity Markets - Policy Services PO BOX 670 STN WATERLOO WATERLOO ON N2J 4B8</p>								