Manulife Financial

CANADIAN PACIFIC RAILWAY

Group Benefits Application for Change

Please print clearly and complete both pages of form.
Please complete SECTIONS 1 & 4 for ALL changes and any other sections that are applicable to your change.
If required, retain a photocopy for your files.

1 General information

We require this information to process your request.

Plan number(s)	Account/Division number(s)	Billing division (if applicable)	Certificate number
84501			

Plan sponsor

Canadian Pacific Railway

Plan member name (last, first, middle initial)

2 Beneficiary change

Note: The effective date of the Beneficiary change will be the date this form is signed.

◯ Change of name only
◯ Change of beneficiary

Relationship to plan member

Name of beneficiary (last, first, middle initial)

Signature of previous irrevocable beneficiary

For Quebec residents only
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

Note: In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If the beneficiary is shown as irrevocable, his/her consent is required to change it.

For designated beneficiaries under the age of 18.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.

3 Termination of dependant coverage

This section only applies if you wish to remove dependants.

Complete this section when you are deleting dependants that have previously been enrolled.

Change type code (see below)	Effective date of change (dd/mmm/yyyy)	Spouse/child name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Relationship code H/W/S/C (see below)	Full-time student? (Yes or No)	Disabled dependant? (Yes or No)
D		spouse		◯ M ◯ F		N/A	N/A
D		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
D		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
D		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No
D		child		◯ M ◯ F		◯ Yes ◯ No	◯ Yes ◯ No

Change type codes: **A** = Add, **C** = Change, **D** = Delete **Relationship codes:** **H** = Husband, **W** = Wife, **S** = Common-law spouse, **C** = Child

If a dependant is disabled, please complete form GL4209E CPR, Request for Over-Age Dependant Coverage/Termination of Over-Age Dependant Coverage.

FOR HEAD OFFICE USE ONLY

Plan number

Certificate number

4 Plan member signature

I designate the person(s) named above as my beneficiary.
I certify that the information in this form is true and complete, to the best of my knowledge.
If applying for benefits for my dependants, I am authorized to release information concerning my spouse and my dependants, for the purposes of determining their eligibility for benefits.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.
If applicable, I authorize my employer to make deductions from my pay for my group benefits.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:
• our employees, service representatives and reinsurers in the performance of their jobs;
• persons to whom you have granted access; and
• persons authorized by law.

You have the right to request access to the personal information in your file, and, if necessary, correct any inaccurate information.

Please sign and date here.

Plan member's signature	Date signed (dd/mmm/yyyy)

5 Mailing instructions

Please send the completed form to: **Group Benefits, Flex Benefits Administration**
Manulife Financial
380 Weber Street N
PO BOX 1662
WATERLOO ON N2J 5A4

For Manulife Financial use only

Multiple Group No.	Effective date of Insurance dd/mmm/yyyy	CLASS	MODE	SAL	LIFE	A D & D	WI	LTD	EHC	DEN	DEP. LIFE	OCC	DIV	COB	DRUG PLAN	LATE EE	LATE DEP	MNL	CII EVA
Multi Accts														Remove Name		Cov Indicator		Expiry date	
EXCESS									HCSA		SENT NOTE		ADDR					Initials	

Ce document est aussi disponible en français sur demande (GL4210F(84501))