

## Group Benefits Refusal of All Coverage

### Instructions

Section 1 - General information

Section 2 - Certification and authorization

Please print all answers

### 1 General information

Plan contract number(s)	Account/Division number(s)	Billing division (if applicable)	Plan member certificate number
Plan sponsor name			
Employer name (if different from plan sponsor)			
Plan member name (first, middle initial, last)			

### Comments


### 2 Certification and authorization

PLEASE NOTE THAT YOU MAY REFUSE COVERAGE **ONLY IF** PARTICIPATION IN YOUR PLAN IS **NOT MANDATORY**.

I have been given an opportunity to participate in my Plan Sponsor's Group Benefit Program under a policy issued, or to be issued, by Manulife Financial and the benefits of the plan have been explained to me. I have given it careful consideration and do not wish to be insured under this plan.

I understand that if I wish to apply for coverage at a later date that I will have to make application in writing and, at my own expense, provide Manulife Financial with medical evidence of insurability for myself and any eligible dependants. However, Manulife Financial retains the right to refuse my application for coverage. If coverage is approved, Dental benefits (if any) will be limited during the first 12 months of coverage.

Plan member signature

Date signed (dd/mmm/yyyy)

### 3 Mailing instructions

Please send your completed form to:

**Plan Member Administration  
Manulife Financial  
PO BOX 2026  
HALIFAX NS B3J 2Z1**