Operating Engineers Local 955 Health & Wellness Plan Retiree Benefit Plan Underwritten by Manulife Enrollment Application

Section 1 is to be completed by the Trust Office. The remaining sections and Beneficiary Designation form are to be completed by the applicant. Please print clearly in dark ink using CAPITAL LETTERS.

1 Plan sponsor statement

Plan sponsor name OPERATING ENGINEERS LOCAL 955 HEALTH & WELLNESS PLAN Plan contract number 31517

Billing division 200 Eligibility date (dd/mmm/yyyy) _____ Plan member's registration number _____

Re-Enrollment ○ Plan administrator's signature _____ Date (dd/mmm/yyyy) _____

2 Plan member information

To be completed by member

Plan member's last name _____ First name _____

Date of birth (dd/mmm/yyyy) _____ Gender ○ Male ○ Female Province of residence _____

Plan coverage selection ○ Basic Single (R1) ○ Enhanced Single (R2) ○ Basic Family (R1) ○ Enhanced Family (R2)

Language ○ English ○ French Do you have a spouse? (married, common law or civil union?) ○ Yes ○ No

3 Plan member address

Address (number, street, apt.) _____

City _____ Province _____ Postal code _____ Phone number _____

4 For Quebec residents (age 65 or over)

Are you participating in the RAMQ drug plan? ○ Yes ○ No

5 Coordination of benefits

This section is required if you are applying for Family coverage.

Do you or your dependants (spouse and/or children) have benefit coverage under another Benefit Plan? ○ Yes ○ No

If *yes*, please provide the following details: Name of other insurer _____

Insured's last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

Effective date of coverage (dd/mmm/yyyy) _____ Identification/certificate number _____ Policy number _____

Please indicate type of coverage under other plan:

In cases where the information is not complete, co-ordination of benefits will be applied. This may result in delays in processing your spouse's claims.

Extended Health Benefits	Dental Care
○ Single	○ Single
○ Family	○ Family

6 Dependant information

If there is not enough room to list your dependants, attach details on a separate sheet.

Complete the following section if applicable.

Spouse's last name _____ First name _____ Date of birth (dd/mmm/yyyy) _____

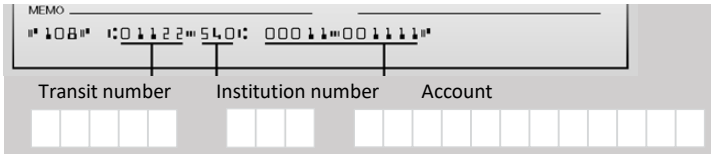
Gender ○ Male ○ Female If common law, please provide the effective date of cohabitation (dd/mmm/yyyy) _____

Last name	First name	Date of birth (dd/mmm/yyy)	Gender Male	Gender Female	Over-age student (21-24 years old)	Over-age disabled dependant
			○	○	○	○
			○	○	○	○
			○	○	○	○
			○	○	○	○

7 Banking information and email address

Complete **only** when providing new or updated information.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.



By providing your email address, you will receive an invitation to register for your Plan Member secure site where you can view your electronic claim statements.

Email address (Please print clearly)

8 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Retiree Benefit Plan issued to my Plan Sponsor by OE955 Health & Wellness Plan Trust Office ('Trust Office') and underwritten by Manulife. **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** the Trust Office and Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Retiree Benefit Plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefit programs to collect, use, maintain and exchange this information with each other, the Trust Office and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration. **I agree** a photocopy or electronic version of this authorization is valid.

If applicable, **I authorize** Manulife to deposit all payment(s) ("Payment(s)") due to me from the above referenced Group Retiree Benefit Plan into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** the Trust Office and Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that the Trust Office and Manulife are not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by the Trust Office, Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by the Trust Office and Manulife.

I understand that any Information provided to or collected by the Trust Office or Manulife in accordance with this authorization, will be kept in a Group Retiree Benefit file. Access to my Information will be limited to:

- Trust Office and Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/planmember or from my Plan Sponsor.

PLEASE SIGN HERE

Signature of plan member _____ Date signed (dd/mmm/yyyy) _____

9 Mailing instructions

Retiree Benefit Plan
Operating Engineers Health & Wellness Trust
17603 – 114 Avenue
Edmonton, AB T5S 2R9