

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
	Plan sponsor Canadian Pacific Railway			
	Plan member name (last, first, middle initial)			

2 Beneficiary change For designated beneficiaries under the age of 18.	Note: The effective date of the Beneficiary change will be the date this form is signed.		
	<input type="radio"/> Change of name only	Relationship to plan member	
	<input type="radio"/> Change of beneficiary		
	Name of beneficiary (last, first, middle initial)		
Signature of previous irrevocable beneficiary			For Quebec residents only If spouse is beneficiary, designation is: <input type="radio"/> Revocable <input type="radio"/> 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.
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		<input type="radio"/> M <input type="radio"/> F		N/A	N/A
D		child		<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
D		child		<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
D		child		<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
D		child		<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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.

Plan number
 Certificate number
FOR HEAD OFFICE USE ONLY

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																					
EXCESS									HCSA		SENT NOTE		ADDR							Initials	

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