

# MTS Optional Life Election/Change Enrolment Form



## Keeping your information confidential

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers and reinsurers who, in some instances, may be located in jurisdictions outside Canada. Your personal information may be subject to the laws of those foreign jurisdictions. Sun Life Financial's operations worldwide and our third-party providers are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at [www.sunlife.ca](http://www.sunlife.ca), or to obtain information about our privacy practices, send a written request by email to [privacyofficer@sunlife.com](mailto:privacyofficer@sunlife.com), or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

## Instructions

- Complete this form if you want to elect coverage or if you want to make a change to the optional life coverage initially selected.
- You must complete the beneficiary sections for those new optional life benefits you are electing. If you are changing your existing optional life coverage and want to change your current beneficiary nomination, please complete the applicable beneficiary section(s). Otherwise, your current optional life beneficiary nomination will remain. If no beneficiary is designated for the optional life benefits, proceeds will be paid to your estate.
- If you and/or your spouse enrol for coverage within 60 days of becoming a member of MTS, or the date you acquire a dependent, you both qualify for up to \$50,000 of coverage without providing proof of good health.

## Note

If your current beneficiary nomination is irrevocable, your current beneficiary must agree to revoke their rights by completing a Consent by Beneficiary form.

Please PRINT clearly. Complete the form in ink, sign and date the form and return to your plan administrator for handling.

## 1 Plan member details

Be sure to complete all plan member information.

Contract number <b>50427</b>	Contractholder name <b>The Manitoba Teachers' Society</b>		Plan member ID (to be completed by Plan Administrator – Mercer)	
Plan member's last name		Middle initial	First name	
Member's address (street number and name)				Apartment or suite
City		Province	Postal code	
Date of birth (dd-mm-yyyy) — —		Telephone number — —		

## 2 Optional life benefits

Complete only for the optional benefits that you are electing or changing.

A Health Statement is required if you are requesting:

- coverage later than 60 days from your date of hire
- coverage later than 60 days for a newly acquired dependent
- more than \$50,000 of coverage
- coverage that was previously declined

### Optional Life

- Plan member    Spouse    Child

### Reason for Application

- New hire/acquired dependent
- Late applicant (after 60 days from date of hire)
- Increase in coverage
- Re-application (previously declined)

Date dependent acquired (dd-mm-yyyy)  
— —

Date of hire (dd-mm-yyyy)  
— —

### Plan member

Have you used tobacco products within the past 12 months?    Yes    No

**Benefits Requested**  
(Please check off)

**A. Existing Amount of Coverage**  
(if applicable)

**B. New Amount of Coverage Requested**

**C. Total Amount of Coverage (A + B)**

- Optional Life – member

\$

\$

\$

(Coverage available in units of \$10,000 to a maximum \$250,000)

Member's date of birth

(dd-mm-yyyy)  
— —

## 2 Optional life benefits (continued)

Your spouse must complete and sign the Spouse Optional Life information if you are electing this coverage.

### Spouse Optional Life

(spouse must complete and sign)

Have you used tobacco products within the past 12 months?  Yes  No

**Benefits Requested (Please check off)**      **A. Existing Amount of Coverage (if applicable)**      **B. New Amount of Coverage Requested**      **C. Total Amount of Coverage (A + B)**

Optional Life – spouse      \$       \$       \$

(Coverage available in units of \$10,000 to a maximum \$250,000)

Spouse's date of birth

I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.

Spouse's signature  
X

When you and/or your spouse participate in the Optional Life plan, each child is eligible for one unit of coverage at no cost to you.

### Child Optional Life

Each child      Number of dependent children \_\_\_\_\_

Add     Change in coverage      Amount of coverage \$ \_\_\_\_\_

(Coverage available in units of \$10,000 per dependent child to a maximum of \$50,000)

			Gender	Student*	Over-age disabled child**
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* A student is a child age 21 or over but under age 25, who is a full-time student attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.

\*\* To enrol an over-age disabled child, complete a Disabled Child Coverage Form, and send it to us within 31 days of the date the dependent reaches the age limit.

Please contact Mercer, your plan administrator, for this form.

## 3 Member beneficiary nomination

### IMPORTANT:

Be sure to show the beneficiary's first and last name, as well as the relationship to you.

You must initial any changes or deletions. Correction fluid cannot be used.

A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.

If you are nominating a beneficiary who is a minor, please see section 6.

### NOTE:

In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian of the minor child.

By completing this section I revoke all previously nominated Optional Life beneficiary nominations and make the following nomination where permitted by law.

Beneficiary for **Member Optional Life (if applicable)**

Last name	First name	Relationship to plan member	Percentage %

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.  Revocable beneficiary

**If you do not nominate a beneficiary, the proceeds will be paid to your estate.**

#### 4 Spouse beneficiary nomination (to be completed by the plan member)

Complete this section if you are applying for or changing spouse optional coverage.

By completing this section I revoke all previously nominated beneficiary nominations and make the following nomination where permitted by law.

Beneficiary for **Spouse Optional Life (if applicable)**

You may nominate yourself or someone other than your spouse as the beneficiary.

If no beneficiary is nominated, you are automatically the beneficiary.

Last name	First name	Relationship to plan member	Percentage %
Last name	First name	Relationship to plan member	Percentage %
Last name	First name	Relationship to plan member	Percentage %

#### 5 Appointing contingent beneficiaries

If you wish to appoint a contingent beneficiary, in the event that there are no surviving beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Unless I specify otherwise, my contingent beneficiary will apply to all benefits. I revoke all previous contingent beneficiary appointments.

Last name	First name	Relationship to plan member	Percentage %
Last name	First name	Relationship to plan member	Percentage %
Last name	First name	Relationship to plan member	Percentage %

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.  Revocable beneficiary

#### 6 Nomination of trustee for minor beneficiary other than Quebec residents

If you wish to designate minor children as beneficiaries, a trustee must be designated.

NOTE: In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian of the minor child.

Any payments becoming due while the beneficiary(s) are a minor\* are to be made to \_\_\_\_\_ as trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payment to the trustee will discharge the company.

\* A minor is a child who has not reached the age of majority as defined by provincial legislation.

#### 7 Premium payment

**Monthly pre-authorized debit (PAD)** (collect my premium directly from my bank account)

First name of account holder		Middle initial	Last name of account holder		
Financial institution name	Financial institution address (street # and name)		Transit #	Institution #	Account #

To use Pre-Authorized debit (PAD) you must agree to all terms of the authorization. By signing below as payor you agree to the following terms and conditions.

## 7 Premium payment – continued

### Terms and conditions

You authorize Mercer to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that Mercer notify you of any payments after the first payment whether the amount of the monthly premium is changed or not.** You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if Mercer is unable to make a withdrawal from your account.

This authorization is to remain in effect until Mercer has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca).

Mercer may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

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 debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder X	Date (dd-mm-yyyy) — —
Signature of account holder X	Date (dd-mm-yyyy) — —

Please photocopy and return your completed Enrolment form to Mercer, your plan administrator, at the address indicated below.

Mercer  
1410 – One Lombard Place  
Winnipeg, Manitoba R3B 0X5

If proof of good health is required for the coverage amounts you are applying for, you'll also have to complete the Health Statement.

## 8 Authorization and signature

**IMPORTANT:**  
You must sign and date  
the form.

I am authorized to disclose information about my spouse and dependents in order to enrol them in the Plan.

By enrolling in this Plan, I authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers, its reinsurers and their service providers to collect, use and disclose relevant information about me to underwrite, administer and adjudicate claims,
- My plan sponsor, and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required,
- Sun Life Assurance Company of Canada, its agents and service providers, and my plan sponsor and its agents to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I understand that satisfactory proof of good health may be required for myself or my spouse to become covered or to increase Optional Employee Life or Optional Spouse Life coverage.

I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.

A photocopy or electronic version of this authorization is as valid as the original. A photocopy or electronic version of this form is not valid for recording beneficiary nominations.

Plan member signature X	Date (dd-mm-yyyy) — —
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**Please complete and return to your Plan Administrator, Mercer, at:**

**1410 – One Lombard Place, Winnipeg, Manitoba, R3B 0X5**

**Remember to photocopy this form for your records.**