Canada Associates

New hires or newly eligible for health insurance? Complete both forms to enroll and attach dependents to your extended health and dental benefits.

Only need to change your beneficiary? Complete pages 4-5 to assign a beneficiary.

All forms MUST be returned to PetSmart HR Shared Services at HRSharedServices@petsmart.com

Manulife

Group Benefits Application for Change

- Section 1 is to be completed by the plan administrator
- The remaining sections and Beneficiary Designation form are to be completed by the plan member
- Please print clearly in dark ink using CAPITAL LETTERS.

1 Plan sponsor statement

Plan sponsor name PetSmart, Inc. Plan contract number 31049

Plan member name (first, last and middle initial) _____

Plan member certificate number _____

I certify that the **plan member** listed below is **actively at work** at their usual place of employment in Canada. **Actively at work** means the **plan member** works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature _____ Date (dd/mmm/yyyy) _____

Registered under the Canadian *Indian Act* for provincial tax exemption purposes? ◯ Yes ◯ No

Is evidence of insurability required? ◯ Yes ◯ No (in order to determine if evidence of insurability is required, please refer to your contract.)

If evidence of insurability is required, plan members must complete GL0004E, *Evidence of Insurability*, and send it to Manulife for processing. **Manulife will not contact your Plan Administrator to verify that this form has been mailed**.

2 Plan member name change

Last name _____ First name _____

3 Plan member address

Address (number, street, apt.) _____

City _____ Province _____ Postal code _____

4 Addition of benefits

A spouse/common-law spouse is considered an eligible dependant under your group plan. Please refer to your contract for guidelines.

Addition of Extended Health Care
I wish to ADD Extended Health Care for

- ◯ Myself ONLY
- ◯ Myself AND 1 dependant
- ◯ Myself and 2 or more dependants
- ◯ My dependants ONLY (I am already covered)

Addition of Dental Care
I wish to ADD Dental Care for

- ◯ Myself ONLY
- ◯ Myself AND 1 dependant
- ◯ Myself and 2 or more dependants
- ◯ My dependants ONLY (I am already covered)

Dependant Life

◯ I wish to add Dependant Life Insurance

Reason for additions (check one only)

- ◯ **Marriage** Date of marriage (dd/mmm/yyyy) _____
- ◯ **Common-law relationship*** Date commenced (dd/mmm/yyyy) _____
- ◯ **Spouse's coverage cancelled** Cancellation date (dd/mmm/yyyy) _____
- ◯ **Other** Effective date (dd/mmm/yyyy) _____

Please give details of "Other". If necessary, attach a separate sheet.

_____

*Please enter the date that the common-law cohabitation began in the "Date commenced" field.

5 For Quebec residents

(age 65 or over) Are you participating in the RAMQ drug plan? ◯ Yes ◯ No

6 Refusal of benefits

You may refuse Extended Health Care and or Dental Care for yourself and/or your dependant(s) only if covered for similar benefits under spouse's plan.

Refusal of Extended Health Care
I do **NOT** want Extended Health Care for

- ◯ Myself ONLY
- ◯ Myself and my dependant(s)
- ◯ My dependant(s) ONLY

Date of refusal (dd/mmm/yyyy) _____

Refusal of Dental Care
I do **NOT** want Dental Care for

- ◯ Myself ONLY
- ◯ Myself and my dependant(s)
- ◯ My dependant(s) ONLY

Date of refusal (dd/mmm/yyyy) _____

Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage at a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.

7 Termination of dependent coverage

◯ I wish to terminate coverage for a specific dependant(s) (see section 9)
◯ I wish to terminate ALL coverages for ALL dependants ◯ Please change coverage to single

Effective date of termination (dd/mmm/yyyy) _____ Reason for termination _____

8 Coordination of benefits

This section is required if you are applying for coverage on your dependants.

Do you or your dependants (spouse and/or children) have benefit coverage under another benefits 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, a default value of Secondary will be applied.

Extended Health Benefits	Dental Care
◯ Single	◯ Single
◯ Couple	◯ Couple
◯ Family	◯ Family
◯ None	◯ None

9 Dependant information Spouse

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

Complete the following section if the plan includes health and/or dental coverage and you have not refused benefits for your dependants in Section 5 Application for coverage.

Last name _____ First name _____

Date of birth (dd/mmm/yyyy) _____ Sex* ◯ Male ◯ Female ◯ Non-binary

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

Last name	First name	Date of birth (dd/mmm/yyyy)	Sex* Male	Female	Non-binary	Over-age student	Over-age disabled dependant**
			◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯

* Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

** To apply for over-age disabled dependant coverage, please complete form GL0514E.

10 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)

11 Authorization and consent

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor 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** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits 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 benefits programs to collect, use, maintain and exchange this information with each other 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** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), 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** 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 Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by 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 Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Centre.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- 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) _____

12 Mailing instructions

Plan Member Administration
Manulife
PO BOX 11006, STN CENTRE-VILLE,
MONTREAL QC H3C 4T8

Manulife

Please see reverse for assistance in completing this form.

Send the completed form to: **Plan Member Administration**
Manulife
PO BOX 11006, STN CENTRE-VILLE
MONTREAL QC H3C 4T8
Fax: 1-877-733-4233

Group Benefits Beneficiary Designation

All sections of this page should be completed as it will replace any prior designations.

1 Plan member information

Plan sponsor name	Plan contract number	Plan member certificate number
PetSmart, Inc.	31049	
Plan member name (last, first and middle initial)	**Province of residence**	**Date of birth (dd/mmm/yyyy)**

2 Primary beneficiary

List all primary beneficiaries for Basic Life and/or Basic Accidental Death.

Percentages must total 100% to be valid.

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
			%
			%
			%

Irrevocability

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
◯ Revocable ◯ Irrevocable

3 Optional coverage (if applicable)

Plan contract number

List all beneficiaries for Optional Life and/or Optional Accidental Death.

Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage
			%
			%
			%

Irrevocability

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
◯ Revocable ◯ Irrevocable

4 Contingent beneficiary

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member

5 Trustee appointment

Complete if any beneficiary named is under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

6 Declaration and authorization

Due to the legal significance of a beneficiary appointment this designation must be signed and dated to be valid.

A copy, fax, scan or image of the beneficiary designation in this form is as valid as the original.

I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.

At Manulife, 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 and service representatives 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.

I acknowledge that more detailed information concerning how and why Manulife collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or by requesting a copy from my plan sponsor.

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

Manulife assumes no responsibility for the validity or sufficiency of the content provided by you. The items 'you' and 'yours' refer to the plan member, the term "Plan Sponsor" refers to the entity that offers the group benefits plan, such as an employer.

What is the purpose of a beneficiary?

If you intend for some or all of your death benefit to go to specific individuals, it is important to make sure that you plan ahead and select those beneficiaries. Having an up-to-date beneficiary designation will make this possible by listing your primary and contingent beneficiaries and intended allocations.

Beneficiary: the person, people or entity who will receive any death benefit from the basic or optional coverage you have selected through your group benefits plan that becomes payable upon your death. Basic and optional beneficiaries may differ.

Types of beneficiary – Primary vs. Contingent

Primary: the person, people or entity you choose to receive the death benefits. If you choose more than one beneficiary, you will need to indicate what percentage of the benefit you would like each person to receive. When multiple primary beneficiaries are named, the total of the percentages allocated to each primary beneficiary must add up to 100%.

Contingent: the person, people or entity you designate to receive the death benefits if all of the primary beneficiaries die before you. If you select more than one contingent beneficiary, the benefit will be split evenly between the contingent beneficiaries.

What happens to the death benefit when...

The primary beneficiary dies before you and no contingent beneficiary is named.	The death benefit will be paid to your estate.
The primary beneficiary dies before you, but there is a contingent beneficiary(ies) designated.	The benefit will be paid to the contingent beneficiary(ies).
You assign two primary beneficiaries, and one beneficiary dies before you, and you have not updated your beneficiary form information.	The entire death benefit that would have been paid to the deceased beneficiary will be paid to the surviving primary beneficiary.

Irrevocable vs. Revocable

Irrevocable: the beneficiary you choose cannot be changed without the written permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you will not be able to change the beneficiary designation without a completed release form from them.

In Quebec, naming your spouse (must be a civil union) as a beneficiary automatically means that he/she is an irrevocable beneficiary, unless you specify otherwise or divorce.

Revocable: a revocable beneficiary means that the beneficiary you choose can be changed at any time without the permission of that individual.
For example, if you choose your spouse or partner to be the designated beneficiary and you end up separating, you can then change that beneficiary designation without asking for that person's permission.

Naming a minor as a beneficiary

If a benefit becomes payable to a minor who is named as a primary or contingent beneficiary, the benefit can only be paid on behalf of the minor to a trustee or guardian for property, otherwise it will be paid into court to be held until the beneficiary has reached the age of majority for your specific province. It is important therefore, if you are choosing a beneficiary who is a minor at the time of the designation to also name a trustee.

If you are a Quebec resident, the parents are considered tutors of their child.

If a minor has been designated as an irrevocable beneficiary, the policy is automatically frozen until the beneficiary has reached the age of majority for your specific province. A parent, guardian or trustee cannot consent to a beneficiary change on behalf of a minor.

Minor: a person named as a beneficiary who is under the age of majority for your specific province.

Trustee: a person appointed by you to hold the minor's proceeds in trust until the minor reaches the age of majority for your specific province.

Tutor: a tutor acts like a trustee.