

ADMINISTRATOR: GLOBAL BENEFITS

MANULIFE FINANCIAL

Policy N^o. 4513

1. Complete the Employee's Statement (below) and include your date of birth and Social Insurance Number.
2. All correspondence, claim forms etc. should be mailed to:

**INSTRUCTIONS
TO
EMPLOYEE**

Global Benefits
545 Wilson Ave., Toronto, ON M3H 1V2
Phone: (416) 635-6000 Fax: (416) 635-6464

3. All receipts should be attached to this form.

DATE OF BIRTH

D	M	Y

SOCIAL INSURANCE NUMBER

--	--	--	--	--	--	--	--	--	--

EMPLOYEE'S STATEMENT

1. Name: _____ Address (Give Number, Street, City & Prov.) _____ Home Phone No. _____

2. Single or Married	Male or Female	Occupation	Postal Code (at home)
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		_ _ _ _ _ _ _

3. IF DEPENDENT CLAIM, please complete.

Name of Dependent	Male or Female	Relationship	Date of Birth	Single or Married
	<input type="checkbox"/> <input type="checkbox"/>		____/____/____ Day Month Year	<input type="checkbox"/> <input type="checkbox"/>

Have you (or your dependent) any other coverage which would pay a benefit for this claim? Yes No

If "Yes", name of Employer and Insurance Co. _____

If "Yes", please indicate spouse's date of birth. _____

If child, indicate Student Handicapped

4. Vision Care Expenses - Attach all receipts and provide the following breakdown:

Frames.....	\$ _____
Lenses Single Vision.....	\$ _____
Multiple-Focal.....	\$ _____
Contacts.....	\$ _____

Have you any other coverage which would pay a benefit for this claim? Yes No

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date ____/____/____ Signature of Member _____ Telephone Number () _____

Day Month Year

FOR ADMINISTRATOR'S USE ONLY