EMPLOYEE ENROLLMENT FORM – de Havilland Aircraft of Canada Limited

1. Employer Section **Indicate location:** (Production, After Market, SGA)	**Company Name:** De Havilland Aircraft of Canada Limited	**Policy Number:** Manulife 37843 / 110963	**Class:**	**Occupation:**
	Date Employed: (mm/dd/yyyy)		**Annual Earnings:** (excluding bonus and OT)	
	Coverage Eff. Date: (mm/dd/yyyy)		**Hours/week:**	

2. Employee Section	**Last Name:**	**First Name:**	**Date of Birth:** (mm/dd/yyyy)
	Gender: Male ◯ Female ◯	**Marital Status:** Single ◯ Married ◯ Common-law: (provide date of cohabitation)	
	Address:	**City:**	**Province:** / **Postal Code:**

3. Dependent Information	**Last Name:**	**First Name:**	**Date of Birth:** (mm/dd/yyyy)	**Gender:**	**Post-Secondary Student Status:**
Spouse				Male ◯ Female ◯	N/A
1st Child				Male ◯ Female ◯	Yes ◯ No ◯
2nd Child				Male ◯ Female ◯	Yes ◯ No ◯
3rd Child				Male ◯ Female ◯	Yes ◯ No ◯

4. Co-ordination of Benefits	Yes ◯ My dependent has coverage under another plan.	**Insured's Name:** (Last, First)	**Insured's ID & Policy No:**	**Date of Birth:** (mm/dd/yyyy)
If you or your dependents (spouse and/or child) have benefit coverage under another benefits plan, **PLEASE COMPLETE SECTION 4.**	**Alternate Coverage**	**Extended Health Care:** Single ◯ Family ◯	**Dental:** Single ◯ Family ◯	
	Waiver Due to Alternate Coverage: *I understand that if my alternate's plan terminates or is significantly reduced, I will have 31 days from the date of termination or change in which to reapply for coverage.*			
	I am waiving Extended Health Care coverage at this time for:	**Myself & Dependents** Yes ◯	**Dependents Only** Yes ◯	
	I am waiving Dental coverage at this time for:	**Myself & Dependents** Yes ◯	**Dependents Only** Yes ◯	

5. Beneficiary Designation — I hereby revoke any previous beneficiary designations in relation to my forgoing coverage(s) and designate the person(s) named below.

	Last Name:	**First Name:**	**Relationship:**	**Date of Birth:** (mm/dd/yyyy)	**Share of Proceeds %** (Must total 100%)
1st Beneficiary					
2nd Beneficiary					
Contingent Beneficiary Designation:	**Last Name:**	**First Name:**	**Relationship:**	**Date of Birth:**	**Share of Proceeds %**
1st Contingent					

For Quebec Applicants Only – Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to his/her tutor(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Manulife has been provided notice of trust. If a valid trust has already been established, designate the trust as beneficiary in this section. **Before designating a trust, you should seek legal advice.**
Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: **Revocable Yes** ◯
For All Other Applicants – If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a trustee/administrator by completing **Section 6. Trustee Clause.** This appointment may not be suitable for all purposes. **Before designating a trust, you should seek legal advice.**
Beneficiaries are revocable unless you write the word "irrevocable" after the beneficiary's name.

6. Trustee Clause
Trustee appointment not available in Quebec.

I, hereby, nominate and appoint the following trustee to receive and disburse any moneys payable under the group policy to my beneficiary(ies) during the minority. Payment to said Trustee shall discharge the company.

Trustee's Name (Last, First): Relationship to Employee:

7. Authorization and Declaration

I hereby apply for coverage under my employer's group plan and authorize my contributions (if any) by payroll deductions. I certify all information I provide is accurate and true and that I am authorized to act on behalf of my spouse/dependents if applicable. By signing this form I authorize:

- The insurer, any health care provider, plan administrator, other insurance companies, or benefit providers working with the insurer to exchange information when necessary to determine my eligibility (and spouse/dependents if any) for coverage and to administer the group benefits plan.

8. Confidentiality

Your group benefits insurer knows that the confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health file. Access to your information will be limited to:

- Our employees, service representatives, and re-insurers 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.

9. Signature

EMPLOYEE'S SIGNATURE ______________________ **DATE:** (mm/dd/yyyy) ______________

IMPORTANT: If you are interested in up to $30,000 of Optional Life Insurance (without medical evidence), please speak to your Plan Administrator/Human Resources Department **within 31 days of your coverage effective date.**

ENROLLMENT FORM INSTRUCTIONS – de Havilland Aircraft of Canada Limited

<table>
<tr><td colspan="2">Enclosed is your Group Benefits Employee Enrollment Form. Please complete Sections 2. - 9. Sign your form and return it to your Plan Administrator or Human Resources Department.</td></tr>
<tr><td>2. Employee Section</td><td>✓ Please provide your personal information.</td></tr>
<tr><td>3. Dependent Information (Spouse and Dependent Children)

It is important to list ALL eligible dependents even if they have health and dental coverage elsewhere. If they were to lose that coverage, then we have the pertinent information making future enrollment much more convenient.</td><td>› All eligible employees and their dependents must be covered under provincial health plan.

› Spouse: Your legal Spouse or the person continuously living with you in a role like that of a marriage partner for at least 12 months

› Eligible Dependent Child:
○ An eligible dependent is one who is under the age 21, or
○ A dependent between ages 21 – 25* provided they are full- time students at a recognized post-secondary educational institution. Please indicate your dependent’s Post-secondary student status by indicating “yes” or “no”.
*Under age 26 in Quebec</td></tr>
<tr><td>4. Co-ordination of Benefits

IMPORTANT: Coordination of benefits coverage occurs when there are two insurance plans that work together to pay an eligible claim. By coordinating benefits, you may receive reimbursement for up to 100% of your eligible expenses.</td><td>› The only benefits that can be waived are Extended Health Care (EHC) and Dental. EHC and Dental can only be waived for Yourself & Dependents OR your Dependent(s) Only, if you have comparable coverage elsewhere (i.e. covered under a spouse’s employer benefits plan).

› Indicate if your spouse and/or dependents have Extended Health Care and/or Dental coverage through their employer, include the Insured’s ID & Policy No, and indicate if they have Single or Family Coverage.</td></tr>
<tr><td>5. Beneficiary Designation

IMPORTANT: You cannot name yourself as a beneficiary. If you do not appoint a beneficiary, the insured amount will be payable to your estate.</td><td>› List your 1st and 2nd beneficiaries for Basic Life and/or Basic Accidental Death. Percentages must total 100% to be valid. If you have more than two beneficiaries, please fill out an additional enrollment form.

› If you notice an error in this section after printing, please cross out the incorrect information, write in the correct information, and initial to ensure that the designation is legally valid.</td></tr>
<tr><td>6. Trustee Clause</td><td>› <u>Complete only if you have named a minor beneficiary</u> (under the age of majority is either 18 or 19 depending on province). Please indicate their relationship to you.</td></tr>
<tr><td>7. Authorization and Declaration</td><td>› Please read this section.</td></tr>
<tr><td>8. Confidentiality</td><td>› Please read this section.</td></tr>
<tr><td>9. Signature</td><td>› Once your enrollment form is complete, please print and sign in ink. Return to your Plan Administrator or Human Resources Depart.</td></tr>
<tr><td colspan="2">For assistance with the completion of your enrollment form, please send your inquiry or question to: <u>tpa@dehoney.com</u></td></tr>
</table>

OPTIONAL LIFE INSURANCE APPLICATION FORM

TIME-LIMITED INSURANCE OFFERING WITHOUT MEDICAL EVIDENCE

You may elect Optional Life Insurance in the amount of $10,000, $20,000, or $30,000 without providing medical evidence of good health. Optional Life Insurance premiums are employee paid via payroll deductions. **To obtain coverage, without having to provide proof of health, complete this form and return it to your Plan Administrator within 31 days of your benefit effective date.** If this form is not received within 31 days of your benefit effective date, medical evidence is required.

1. Employee Information

Last Name:	First Name:	Date of Birth: (mm/dd/yyyy)	
Gender: Male ◯ Female ◯	The Manufacturers Life Insurance Company (Manulife) Policy No: 37843		
Address:	City:	Province: ON	Postal Code:

2. Employee Coverage Election
(Premium rates are shown on the reverse side of this form.)

- I am applying for: ◯ $10,000 ◯ $20,000 ◯ $30,000
- Do you now, or have you smoked any cigarettes within the past 12 months? **Yes** ◯ **No** ◯
- If you would like to apply for an amount above the $30,000 evidence-free amount, contact your HR or Plan Administrator for an Evidence of Insurability form. (See the reverse for more information.)

3. Optional Life Insurance Beneficiary Designation

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

	Last Name:	First Name:	DOB:	Relationship:	Share of Proceeds % (Must total 100%)
1st Beneficiary					
2nd Beneficiary					
3rd Beneficiary					

For Quebec Applicants Only – Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to his/her tutor(s)., unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Manulife has been provided notice of trust. If a valid trust has already been established, designate the trust as beneficiary in this section. **Before designating a trust, you should seek legal advice.**

Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: **Revocable Yes** ◯

For All Other Applicants – If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a trustee/administrator by completing **Section 4. Trustee Clause.** This appointment may not be suitable for all purposes. **Before designating a trust, you should seek legal advice.**
Beneficiaries are revocable unless you write the word "irrevocable" after the beneficiary's name.

4. Trustee Clause
Trustee appointment not available in Quebec.

I, hereby, nominate and appoint the following trustee to receive and disburse any moneys payable under the group policy to my beneficiary(ies) during the minority. Payment to said Trustee shall discharge the company.

Trustee's Name (Last, First): Relationship to Employee:

5. Authorization and Declaration

I hereby apply for Optional Life coverage under my employer's group plan and authorize my contributions (if any) by payroll deductions. I certify all information I provide is accurate and true and that I am authorized to act on behalf of my spouse/dependents if applicable. By signing this form I authorize:

- The insurer, any health care provider, plan administrator, other insurance companies, or benefit providers working with the insurer to exchange information when necessary to determine my eligibility (and spouse/dependents if any) for coverage and to administer the group benefits plan.

6. Confidentiality

Your group benefits insurer knows that the confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health file. Access to your information will be limited to:

- Our employees, service representatives, and re-insurers 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.

7. Signature

EMPLOYEE'S SIGNATURE **DATE:** (dd/mmm/yy)

IMPORTANT: This opportunity is available **within 31 days of your benefit effective date.** For more information on this coverage and the rates, please see the reverse side of this form.

OPTIONAL LIFE INSURANCE FAQ

TIME-LIMITED INSURANCE OFFERING WITHOUT MEDICAL EVIDENCE

WHO IS ELIGIBLE?

An employee is eligible to apply for Employee Optional Life Insurance if the employee is actively at work on the date of application and has Basic Life Insurance coverage through the de Havilland Aircraft of Canada Limited plan.

The **ORIGINAL** completed and signed form must be received by your Plan Administrator within 31 days of your benefit effective date.

Age restriction: The employee must be under age 70. Employee Optional Life Insurance terminates when the employee reaches age 70.

Suicide clause: No benefits will be paid for suicide within the first two years after Optional Group Life Insurance goes into effect or increases.

HOW DO I APPLY?

Complete the Optional Life Insurance Application form and provide the **ORIGINAL** signed copy to your Plan Administrator. The **ORIGINAL** completed and signed form must be received within 31 days of your benefit effective date.

If the application form is received **after 31 days of your benefit effective date**, the employee is not eligible for Non-Evidence Medical Optional Life Insurance. Please see HR or your Plan Administrator to discuss applying for Optional Life Insurance by providing the Evidence of Insurability Form.

HOW DO I APPLY FOR ADDITIONAL OPTIONAL LIFE INSURANCE COVERAGE ABOVE $30,000?

If you wish to apply for an amount above the $30,000 evidence-free amount, contact your Plan Administrator for the Evidence of Insurability form. Manulife's medical underwriter will review the completed form and confirm the effective date of coverage or request additional information. If declined for additional insurance, up to $30,000 in coverage is still available to be purchased as long as this application is received within 31 days of your benefit effective date.

OPTIONAL LIFE INSURANCE MONTHLY PREMIUM

Monthly premium will be paid by the employee through payroll deductions. Premiums are based upon age, gender and smoking status. For example, the cost of $30,000 of Optional Life Insurance coverage for a male, age 45 and a non-smoker is $7.71 per month. The cost of $30,000 of Optional Life Insurance coverage for a female, age 45 and a non-smoker is $7.47 per month. Male and female rates refer to sex-at-birth.

Monthly premium for each unit of $10,000 of Optional Life Insurance				
Age of Employee	**Male Non-Smoker**	**Male Smoker**	**Female Non-Smoker**	**Female Smoker**
24 Years and Less	$ 1.31	$ 2.08	$ .40	$ .68
25 to 29	$ .90	$ 1.45	$ .40	$ .69
30 to 34	$ 1.14	$ 1.99	$ .49	$ .84
35 to 39	$ 1.33	$ 2.34	$ .80	$ 1.39
40 to 44	$ 1.69	$ 2.99	$ 1.43	$ 2.51
45 to 49	$ 2.57	$ 4.60	$ 2.49	$ 4.41
50 to 54	$ 4.45	$ 8.01	$ 4.09	$ 7.33
55 to 59	$ 8.07	$ 14.89	$ 6.70	$ 12.33
60 to 65	$ 11.97	$ 22.63	$ 9.87	$ 18.64
66 to 70	$ 21.67	$ 38.76	$ 18.00	$ 32.17