Manulife Financial

APPLICATION FOR CHANGE
TO REQUEST A BENEFIT DOWNGRADE
AFFINITY MARKETS POLICY SERVICES

PART A – GENERAL INFORMATION

Plan Number:	ID Number:	
Policy Holder's Last Name:	First Name:	Initial:

I,_____hereby request that my policy coverage be changed as follows:

☐ Remove add-on benefit -_____(indicate name of benefit to be removed i.e. Travel +8 days, Travel +21 days, Vision Enhanced, Extended Health Care Enhanced, Hospital Cash, Hospital Basic, Hospital Enhanced.)

or

☐ Change current plan to _____

NOTE: THIS FORM SHOULD NOT BE USED TO UPGRADE YOUR PLAN OR ENROLL ADDITIONAL PLAN MEMBERS.

Applicant's Declaration

The Applicant and Co-Applicant, if any, Must Complete This Section
This plan is underwritten by The Manufacturers Life Insurance Company

I/We hereby acknowledge that the statements contained herein are true and complete and together with any other forms signed by me/us in connection with the application form the basis for any policy issued hereunder. I/We acknowledge receipt of and agree with Notice on Privacy and Confidentiality previously provided with the application, additional copies of which can be obtained from The Manufacturers Life Insurance Company, upon request. I/We understand and agree that the coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original. I/We also understand and agree that any changes will be effective the first of the month following receipt of the completed form.

_____ _____ _____

Signature of Policy Holder *Signature of Co-Applicant* *Dated (dd/mm/yyyy)*