

SHERIDAN NURSERIES

ENROLLMENT FORM (for group insurance benefits) COMPLETE ALL AREAS, PRINT CLEARLY



Policy No. 901803/4	Plan Sponsor Canadian Nursery La	andscape Association	Certificate Number					
Participating Employer Sheridan Nurs	eries Limited	Last Name	First Name					
Birth Date (mm/dd/yyyy)	Prov. of Residence	Effective Date (mm/dd/yyy	y) Division Number Class					
Date Employed (mm/dd/yyyy)	Occupation		Marital Status Single (S) Married (M)					
Salary- (Annually, Monthly, Weekly or Hourly)	Scheduled Hours Per Week		Widowed (W) Divorced (D) Common-Law (F) Separated (O)					
Type of Health Coverage Required	Employee only	nd Family None – I w	aive this benefit as I have coverage elsewhere					
Type of Dental Coverage Required Employee only Employee and Family None – I waive this benefit as I have coverage elsewhere								
If none of the above are checked, I understa Insurability requirements as outlined in the	nd that if I want to apply for these o group contract and may not be able	coverages at a later date, I and/or e to enter the plan without the app	r my dependents will have to satisfy the Evidence of proval of MANULIFE FINANCIAL.					
X								
Employee Signa	iture	Date						
	n on:	ee and/or Spousal Life Insuran ee Accidental Death and Disme ee and/or Spousal Critical Illne Dependent Life and Accidental Death	ce* emberment Insurance * ess Insurance and Dismemberment.					
BENEFICIARY FOR BASIC/OPTION I make the following beneficiary designation Name of Beneficiary			NCE					
First	Last	Date of Birth	Relationship to Employee					
If a minor (under age 18) is designated as a	beneficiary please assign a trustee		Deletionship					
Revocable/Irrevocable X	(the term revo	Name ocable/irrevocable must be handw	Relationship written)					
	ence of an irrevocable/revocable de	esignation, the legal spouse is dee	emed to be irrevocable and other beneficiaries are					
X								
Signature	of Employee		Date					

Sept. 19/07(Dep)

Please complete this section if you have applied for dependent coverage.

	Name(s)		" ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	Sex	Date of Birth	Full-time Student	Disabled
	First	Initial	Last	M/F	mm/dd/yyyy	~	Y
Spouse							
Child							
Child							
Child							
Child							

Is y	your spouse presently	y covered under another insurance plan?]Yes					
Ify	yes, please provide:	Name of insurance company	Policy number					
	•	oyer to make the appropriate payroll deductions sfactory evidence of insurability must be providence.	ed by myself or my spouse to become eligible for Optional					
	Employee/Spouse Life Insurance benefit. I understand that on the date my insurance becomes effective with Manulife Financial that I must be actively-at-work. I also understand that the date my dependent's insurance becomes effective with Manulife Financial that they cannot be confined to home or hospital.							
•	I authorize WEBS and Manulife Financial to collect, use and disclose personal information concerning me and/or my dependent(s) (where applicable) for the purpose of determining eligibility for Manulife products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca or by request.							
X	Signature of Employee		Date					
For	r Office Use Only							
Tit	le:							
Em	ployment Date:							
Rat	te of Pay:							
Cos	st Centre:							
Pay	roll Number:							