Group Membership Disabled Child Continuation Form

Owner Information:

Name:		Social Security Number (Last 4 digits):
Address:		
City:	State:	Zip:
Group Policyholder Name:	Group Policy Number/Certificate Number:	

Dependent Information:

Name:	Social Security Number (Last 4 digits):
Date of Birth:	

I hereby certify that the dependent child named above fulfills the following requirements:

(1) is my unmarried child;

(2) is mentally and/or physically incapable of self sustaining employment;

(3) is financially dependent upon the insured named above or other care provider for support and maintenance.

With respect to this child, I am requesting continuance of the dependent coverage which would otherwise terminate on the date this child becomes ineligible for coverage under the Group Policy because of age. If approved, I understand this benefit will end when such child is no longer disabled or New York Life does not receive annual proof.

Please sign below and return with a physician's declaration stating that such child is disabled as described above.

Signature _____ Date (mm/dd/yyyy) _____

Print Your Name _____

RECORDED ON BEHALF OF NEW YORK LIFE, subject to the terms and conditions of the group policy.

By _____ Date (mm/dd/yyyy) _____

Please return this completed form to: Manulife, P.O. Box 17001, Stn Waterloo, Waterloo, Ontario N2J 0G5. manulife.ca
Assistance is available at 1.888.596.8881 between 8 a.m. and 8 p.m. ET, Monday through Friday.