

Full Legal Company Name: Volta Labs Incorporated

Location #: 39127-039

Effective Date: May 1/14

Renewal will be July 1, 2015

Company Address:

5415 Spring Garden Road, Halifax, NS

B3J 1G1

Communitech Member?  
CDMN

9 Digit Rev. Can. Bus. #: 819200536

Nature of Business: Business Incubation

**Benefit Options:**Waiting Period for Current\* Employees  
Waiting Period for New\* EmployeesLife Insurance/AD&D  
(Mandatory)Dependent Life Insurance  
(Not Mandatory)Short Term Disability  
(Not Mandatory)Long Term Disability  
(Mandatory)Extended Health Care  
(Mandatory)Semi-Private Hospital  
(Not Mandatory)Vision Care  
(100% Coinsurance)  
(Not Mandatory)

Dental Care

Employee Assistance Plan (EAP)  
(Not Mandatory)Yes ☒ No ☐Immediate ☒  
Immediate ☒Life 1 ☒  
1 x Salary ☒Dep Life 1 ☐  
\$5,000/\$2,500 ☐STD 1 ☒  
Taxable ☐LTD 1 ☒  
\$10K Max ☐  
Taxable ☐EHC 1 ☒  
Basic ☐SP 1 ☒  
Yes ☐\$200 ☒  
Every 24 Months ☐Dental 1 ☒  
Basic ☐Yes ☐  
No ☒3 Months ☐  
3 Months ☐Life 2 ☐  
2 x Salary ☐Dep Life 2 ☐  
\$10,000/\$5,000 ☐STD 2 ☐  
Non-Taxable\* ☐LTD 2 ☐  
\$10K Max ☐  
Non-Taxable\* ☐EHC 2 ☐  
Enhanced ☐SP 2 ☐  
No Coverage ☐\$300 ☐  
Every 24 Months ☐Dental 2 ☐  
Enhanced ☐No ☐  
No ☒\*Current = Hired prior to effective date of this plan  
\*New = Hired after effective date of this planLife 3 ☐  
\$30,000 ☐Dep Life 3 ☒  
No Coverage ☐STD 3 ☐  
No Coverage ☐LTD 3 ☐  
\$5K Max ☐  
Taxable ☐EHC 3 ☐  
Premium ☐No Coverage ☐No Coverage ☐Dental 3 ☐  
Premium ☐No ☐  
No ☒\*Non-Taxable STD must be 100%  
Employee Paid\*Non-Taxable LTD must be 100%  
Employee Paid



## Group Benefits e-Beneficiary Designation

All sections of this form should be completed as it will replace any prior designations.

Please send the completed form to: **Plan Member Administration  
Manulife Financial  
PO BOX 2026  
HALIFAX NS B3J 2Z1**

<b>1 Plan member information</b>	Plan sponsor name <u>Volta Labs Incorporated.</u>	Plan contract number	Plan member certificate number	
	Plan member name (last, first and middle initial) <u>BARBARA, ROBERT M</u>	Province of residence <u>NS</u>	Date of birth (dd/mmm/yyyy) <u>15/AUG/1967</u>	
<b>2 Basic coverage</b>  List all beneficiaries for Basic Life and/or Basic Accidental Death.  Percentages must total 100% to be valid.  Complete if the beneficiary is under the age of majority.  <b>Irrevocability</b>	Name of beneficiary (last, first and middle initial) <u>THORSTEINSON, ROBIN E</u>	Date of birth (dd/mmm/yyyy) <u>20/OCT/1974</u>	Relationship to plan member <u>SPOUSE</u>	Percentage <u>100</u> %
	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %
	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %
	I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).			
<b>For Quebec residents only</b> In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If spouse is beneficiary, designation is: <input type="radio"/> Revocable <input type="radio"/> Irrevocable		Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. <b>You are responsible for ensuring the validity of your designation.</b>		
<b>3 Optional coverage (if applicable)</b>  Plan contract number _____  List all beneficiaries for Optional Life and/or Optional Accidental Death.  Complete if the beneficiary is under the age of majority.  <b>Irrevocability</b>	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %
	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %
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<b>4 Contingent beneficiary</b>	You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiary(ies) you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.			
	Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	
	Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	
<b>5 Declaration and authorization</b>	<b>I hereby</b> revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.  At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to: • our employees and service representatives 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.  <b>I acknowledge</b> that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at <a href="http://www.manulife.ca">www.manulife.ca</a> or by requesting a copy from my plan sponsor.			
	Plan member signature <u>[Signature]</u>	Date signed (dd/mmm/yyyy) <u>APRIL 10 2015</u>		





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Manulife Financial  
PO BOX 2026  
HALIFAX NS B3J 2Z1**

*All sections of this form should be completed as it will replace any prior designations.*

<b>1 Plan member information</b>	Plan sponsor name	Plan contract number	Plan member certificate number	
	Plan member name (last, first and middle initial) <i>Vrekic, Milan</i>	Province of residence <i>NS</i>	Date of birth (dd/mmm/yyyy) <i>07/09/1984</i>	
<b>2 Basic coverage</b>  List all beneficiaries for Basic Life and/or Basic Accidental Death.  Percentages must total 100% to be valid.  Complete if the beneficiary is under the age of majority.  <b>Irrevocability</b>	Name of beneficiary (last, first and middle initial) <i>Hryshyna, Yauheniuya</i>	Date of birth (dd/mmm/yyyy) <i>19/03/1985</i>	Relationship to plan member <i>Wife</i>	Percentage <i>100 %</i>
	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %
	Name of beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Percentage %
	I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).			
	<b>For Quebec residents only</b> In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If spouse is beneficiary, designation is: <input type="radio"/> Revocable <input type="radio"/> Irrevocable		Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. <b>You are responsible for ensuring the validity of your designation.</b>	
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	Name of contingent beneficiary (last, first and middle initial)	Date of birth (dd/mmm/yyyy)	Relationship to plan member	
<b>5 Declaration and authorization</b>  This designation must be signed and dated to be valid.	<b>I hereby</b> revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named above.			
	At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to: <ul style="list-style-type: none"> <li>• our employees and service representatives in the performance of their jobs;</li> <li>• persons to whom you have granted access; and</li> <li>• persons authorized by law.</li> </ul> You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.			
	<b>I acknowledge</b> that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at <a href="http://www.manulife.ca">www.manulife.ca</a> or by requesting a copy from my plan sponsor.			
	Plan member signature <i>[Signature]</i>	Date signed (dd/mmm/yyyy) <i>07/04/2014</i>		

19/19

To: Manulife Financial

Fr: Melody Pardoe, Volta Labs

Re: Payment For First month of coverage.

**VOLTA LABS INCORPORATED**  
5415 SPRING GARDEN RD  
HALIFAX NOVA SCOTIA B3J1G1  
T: 902 292 0970

000122

DATE 2014-04-18  
Y Y Y Y M M D D

PAY to the order of Manulife Financial

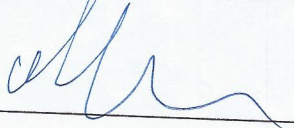
Six Hundred and Forty Six dollars

**ROYAL BANK OF CANADA**  
SPRING GARDEN & SUMMER BRANCH  
5855 SPRING GARDEN RD  
HALIFAX, NOVA SCOTIA B3H 4S2


**RBC**

**VOLTA LABS INCORPORATED**

RE Health Plan - Volta Labs.

PER 

\$ 646.36

36 DOLLARS  Security features included.

100

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