



5415 Spring Garden Road  
Halifax NS, B3J 1E7  
[www.voltaeffect.com](http://www.voltaeffect.com)

April 4, 2014

Ms. Penny Zanussi  
Principal Consultant  
Cowan Insurance Group  
705 Fountain Street North,  
PO Box 1510  
Cambridge, ON N1R 5T2

Dear Penny:

This letter confirms the appointment of Cowan Insurance Group to act as our consultants with respect to the group benefits program for Milan Vrekic, Rob Barbara, and Melody Pardoe, effective April 1, 2014.

You are hereby authorized:

- to receive any information requested regarding existing or future plans from any insurance company or organization administering and underwriting such plans;
- to receive commissions/fees associated with the programs;
- to review, analyse, consolidate and market the programs and make recommendations.

Yours truly,

  
X   
Melody Pardoe  
Programs Director



## Electronic Administration of Policy Agreement

between

The Manufacturers Life Insurance Company ("Manulife")

and

VOLTA LABS INCORPORATED ("Policyholder"), Re: Policy # 39127 (the "Policy")  
- 039

Whereas Manulife has created an Internet site to assist Group Benefits Policyholders in the routine administration of their plans (the "Site");

Whereas the Policyholder has requested that Manulife provide it with access to the Site, then in consideration of Manulife providing access to the Site to the Policyholder, subject to the terms set out below, the mutual promises set out in this Agreement, and other good and valuable consideration, the parties agree as follows:

- (a) Manulife will provide the Policyholder with access to the Site on condition that the Policyholder complies with the Policyholder obligations described in the Terms and Conditions for Use of the Site (the "Terms"), which Terms are found or may be accessed through the Site, as well as the **Personal Information Protection and Electronic Documents Act**, S.C. 2000, c.5 or any supplanting legislation.
- (b) The Policyholder shall advise Manulife in writing of the name of the person(s) it designates to administer the Policy (the "Plan Administrator"), and shall notify Manulife immediately should the Plan Administrator be changed.
- (c) The Policyholder hereby appoints its Plan Administrator to review the Terms on the Policyholder's behalf and agrees that electronic acceptance of the Site's Terms (including acceptance of any subsequently updated Terms) by the Plan Administrator shall be binding upon the Policyholder. Once accepted, the Terms shall form part of this Agreement.
- (d) This Agreement shall terminate automatically on the date the Policy terminates, unless terminated earlier in accordance with the Terms, although in either case, certain of the Policyholder's obligations, identified in the Terms shall survive the termination of this Agreement.
- (e) The use of the Site shall be deemed to occur in the Province of Ontario, so that the laws of the Province of Ontario and the federal laws of Canada applicable therein shall govern the use of the Site and the interpretation of this Agreement.

Signed at Volta, this 7 day of April, 2014.

### Policyholder or Authorized Representative

X M Pardoe  
Signature

X Melody Pardoe  
Name (Please Print)

Send completed forms to:  
PA Internet Registration, Manulife Financial Group Benefits  
380 Weber Street, North, P.O. Box 1650  
Waterloo, ON N2J 4V7

Admin Use Only	SecureServe
New MLI HP	MLAC GIS 1
MLAC GIS 3.0	MLI VO



**Full Legal Company Name:** Volta Labs Incorporated

39127-039

- Employee Optional Life Insurance ? Yes\*  No  \*If Yes, Cowan will send more information
- Optional Critical Illness ? Yes\*  No  \*If Yes, Cowan will send more information
- Health Care Spending Account Option ? Yes\*  No  \*If Yes, Cowan will send more information  
(Not Mandatory)

\*If Yes: Annual amount per employee:

Is annual amount to be pro-rated for current employees at implementation?  Yes  
 Is annual amount to be pro-rated for new employees going forward?  Yes  
 Pre-Authorized Debit (PAD) Billing  Yes  No  X

Are there any employees not actively at work? ?

Are there any known high claimants? ?

**Premium Cost Sharing\*:**

Employer Paid Benefits &amp; Percentages:

Employee Paid Benefits &amp; Percentages:

\*Employer is responsible for paying at least 50% of total premium  
 (Optional Life and CI - employee paid if these benefits are elected)

100 %

6 %

**Future Step Group RRSP\*:**Yes  No  \*Group RRSP**Plan Administrator Details:**

(Plan Administrator will have access to Manulife website for group administration purposes)

Contact For:

Melody Faroche, Programs Director  
 Name & Title

902-880-8341  
 Phone Number

Email

Melody@VoltaEffect.com**Signing Authority Details:**

Contact For:

Milan Vukovic, Executive Director  
 Name & Title

Phone Number

Email

Milan@VoltaEffect.com

April 4 2014  
 Date

X X X  
 Signature



For your future™

## Group Benefits – e-Enrolment or Re-enrolment Application

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

### 1 Plan sponsor statement

To be completed and signed by plan sponsor.

Enter member's certificate number, if known. Otherwise leave blank for Manulife Financial to complete.

Plan contract number <b>39127</b>	Account/Division number <b>039</b>	Billing division (if applicable)	Plan member certificate number
Plan sponsor name <b>Volta Labs</b>	Plan sponsor telephone number (902) 292-0970		
Provide permanent full time hire date (dd/mmm/yyyy) <b>X 01/MAY/2013</b>	If a re-hire, provide the date previous employment ended (dd/mmm/yyyy)	Re-hire date (dd/mmm/yyyy)	
Plan member's occupation Investment Manager	Class	Regular hrs./week <b>X 40</b>	Annual earnings <b>\$ 80,000</b>
<p><b>I certify</b> that the plan member listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.</p> <p>Plan administrator signature <i>M. Ward</i> X <b>07/April/2014</b></p> <p>Date signed (dd/mmm/yyyy)</p>			
<p>Is evidence of insurability required? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If evidence of insurability is required, plan members must complete GL0004E, Evidence of Insurability, and send it to Manulife Financial for processing. Manulife Financial will not contact your Plan Administrator to verify that this form has been mailed.</p>			

In order to determine if evidence of insurability is required, please refer to your contract.

### 2 Plan member information

We require this information to enrol you in the plan.

Plan member name (last, first, middle initial) (please print) <b>Barbara, Rob</b>	Date of birth (dd/mmm/yyyy) <b>15/Aug/1967</b>	
Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	Province of residence <b>Nova Scotia</b>	Language of preference <input checked="" type="radio"/> English <input type="radio"/> French

### 3 Plan member address

Address (number, street, apt. number) <b>1930 Parkwood Terrace</b>	City <b>Halifax</b>	Province <b>NS</b>	Postal code <b>B3H 4G3</b>
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### 4 Applying for coverage

**Note:** You may refuse benefits for yourself and your dependant(s)/spouse ONLY if you are covered for similar benefits under your spouse's plan. If you wish to add this coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

<b>Applying for Health and Dental Benefits</b>		
Health	Dental	Myself ONLY
<input type="radio"/>	<input type="radio"/>	Myself AND 1 dependant/spouse
<input checked="" type="radio"/>	<input type="radio"/>	Myself and 2 or more dependants/spouse
<input type="radio"/>	<input type="radio"/>	None, because my spouse has coverage
<b>Dependant Life</b>		<b>Note:</b> If you have eligible dependants, refusal of this benefit is not allowed on an AlphaPlus plan.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No If common-law spouse, provide the date the co-habitation commenced Date (dd/mmm/yyyy)

### 5 Coordination of benefits

If you do not have a spouse, this section does not apply.

This information is important for the correct adjudication of your claims.

<b>Spousal Health Coverage</b>	Does your spouse have health coverage under his/her own insurance plan?	<input type="radio"/> Yes <input checked="" type="radio"/> No Effective date (dd/mmm/yyyy)
<b>Spousal Dental Coverage</b>	Does your spouse have dental coverage under his/her own insurance plan?	<input type="radio"/> Yes <input checked="" type="radio"/> No Effective date (dd/mmm/yyyy)
<b>Does your spouse's health/dental plan cover:</b>		
Health	Dental	Your spouse only
<input type="radio"/>	<input type="radio"/>	Your spouse and yourself only
<input type="radio"/>	<input type="radio"/>	Your spouse and children only
<input type="radio"/>	<input type="radio"/>	Your spouse, you and your children
		Spouse's date of birth (dd/mmm/yyyy)

**6 For Quebec residents  
(age 65 or over)**

- I am participating in the RAMQ drug plan provided by the Quebec government  
 I am NOT participating in the RAMQ drug plan provided by the Quebec government

**7 Family information**

Complete this section only if you are required to enrol your spouse and/or dependants.

If more than 4 children, please attach a separate listing.

If requesting family coverage, please ensure your spouse and children are listed below, regardless of whether they have health or dental care coverage under another plan.

Spouse/child name Include last name if different from your last name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Relationship code H/W/S/C (see below)	Full-time student? (Yes or No)
spouse <i>Thorsteinson, Robin</i>	<i>20/10/1974</i>	<input type="radio"/> M <input checked="" type="radio"/> F	<i>W</i>	<i>N/A</i>
child <i>Barbara, Samson</i>	<i>11/02/2003</i>	<input type="radio"/> M <input type="radio"/> F	<i>C</i>	<input checked="" type="radio"/> Yes <input type="radio"/> No
child <i>Barbara, Isaac</i>	<i>26/10/2004</i>	<input checked="" type="radio"/> M <input type="radio"/> F	<i>C</i>	<input checked="" type="radio"/> Yes <input type="radio"/> No
child <i>Barbara, Charles</i>	<i>30/08/2007</i>	<input type="radio"/> M <input type="radio"/> F	<i>C</i>	<input checked="" type="radio"/> Yes <input type="radio"/> No

Relationship codes: H = Husband, W = Wife, S = Common-law spouse, C = Child

If a dependant is disabled and over-age, please complete GL0514E, Application for Over-Age Disabled Dependant Coverage.

**8 Beneficiary designation**

For benefits payable upon death, the beneficiary will be ESTATE. If you would like to designate a named beneficiary other than "ESTATE", please complete and sign GL1435E, Beneficiary Designation.

**9a Direct deposit**

Complete the following section if you would like to sign up for direct deposit of your claim payments.

Name of financial institution

Address (number, street) <i>55 KING ST WEST AT BAY TORONTO</i>	City <i>TORONTO</i>	Province <i>ON</i>	Postal code <i>M5H 1H1</i>
Transit number (5 digits) <i>04382</i>	Institution number <i>002</i>	Bank account number <i>0091987</i>	
 <b>Manulife Bank</b> 500 KING ST. NORTH WATERLOO, ONTARIO N2J 4C6			
The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter. MEMO _____ 			
Transit number	Institution number	Account number	

**9b Electronic claim statement**

By completing the email section, you will be sent an invitation to register for an online member account.

Complete the following section only if your plan offers online services and you wish to enroll for the service.

If the email and banking fields are completed you will receive an electronic claim statement, otherwise you will receive your claim statement by mail.

Email

*rob@buildventures.ca*

*work\_email*

**10 Plan member signature**

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("Manulife"). I understand that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). I certify that the information in this form is true and complete to the best of my knowledge. I understand that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependents, in the future is true and complete to the best of our knowledge. I acknowledge and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. I authorize Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. I am authorized by my Dependents to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. I authorize my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. I authorize the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. I agree a photocopy or electronic version of this authorization is valid.

If applicable, I authorize Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. I confirm that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative. I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). I also understand and agree that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). I also hereby acknowledge and agree that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, I authorize Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. I understand such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. I agree that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. I agree should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. I understand that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

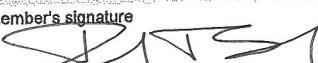
I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at [www.manulife.ca/groupbenefits](http://www.manulife.ca/groupbenefits), or from my Plan Sponsor.

Please sign and date here.

Plan member's signature

Date signed (dd/mmm/yyyy)

 APR 7 2014

**11 Mailing instructions**

Please send the completed form to:

Plan Member Administration  
Manulife Financial  
PO BOX 2026  
HALIFAX NS B3J 2Z1

La version française du document se trouve à l'adresse [www.manuvie.com/assurancecollective](http://www.manuvie.com/assurancecollective).



For your future™

## Group Benefits – e-Enrolment or Re-enrolment Application

Please print clearly and complete all pages of form. If required, retain a photocopy for your files.

### 1 Plan sponsor statement

To be completed and signed by plan sponsor.

Enter member's certificate number, if known. Otherwise leave blank for Manulife Financial to complete.

Plan contract number <i>39127</i>	Account/Division number <i>039</i>	Billing division (if applicable)	Plan member certificate number
Plan sponsor name <i>Volta Labs</i>	Plan sponsor telephone number (902) 292-0970		
Provide permanent full time hire date (dd/mmm/yyyy) <i>X 01/05/2013</i>	If a re-hire, provide the date previous employment ended (dd/mmm/yyyy)	Re-hire date (dd/mmm/yyyy)	
Do you want the waiting period added to the permanent full time hire date?		<input type="radio"/> Yes	<input checked="" type="checkbox"/> No
Plan member's occupation <i>Executive Director</i>	Class	Regular hrs./week <i>X 40</i>	Annual earnings \$ 80,000

I certify that the plan member listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature  
*M*

Date signed (dd/mmm/yyyy)  
*X 07/04/2014*

In order to determine if evidence of insurability is required, please refer to your contract.

Is evidence of insurability required?  Yes  No

If evidence of insurability is required, plan members must complete GL0004E, Evidence of Insurability, and send it to Manulife Financial for processing. Manulife Financial will not contact your Plan Administrator to verify that this form has been mailed.

### 2 Plan member information

We require this information to enrol you in the plan.

Plan member name (last, first, middle initial) (please print) <i>Vrekic, Milan</i>	Date of birth (dd/mmm/yyyy) 07/Sep/1984	
Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	Province of residence Nova Scotia	Language of preference <input checked="" type="radio"/> English <input type="radio"/> French

### 3 Plan member address

Address (number, street, apt. number)

*205 Nadia drive*

City

*Dartmouth*

Province

Postal code

*N.S. B3A 0B1*

### 4 Applying for coverage

Note: You may refuse benefits for yourself and your dependant(s)/spouse ONLY if you are covered for similar benefits under your spouse's plan. If you wish to add this coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

#### Applying for Health and Dental Benefits

Health      Dental

- |                                  |                       |  |
|----------------------------------|-----------------------|--|
| <input type="radio"/>            | <input type="radio"/> | Myself ONLY                            |
| <input type="radio"/>            | <input type="radio"/> | Myself AND 1 dependant/spouse          |
| <input checked="" type="radio"/> | <input type="radio"/> | Myself and 2 or more dependants/spouse |
| <input type="radio"/>            | <input type="radio"/> | None, because my spouse has coverage   |

#### Dependant Life

Yes  No

Do you have a common-law spouse?

Note: If you have eligible dependants, refusal of this benefit is not allowed on an AlphaPlus plan.

Yes  No

If common-law spouse, provide the date the co-habitation commenced.

Date (dd/mmm/yyyy)

### 5 Coordination of benefits

If you do not have a spouse, this section does not apply.

This information is important for the correct adjudication of your claims.

Spousal Health Coverage      Does your spouse have health coverage under his/her own insurance plan?

Yes  No

Effective date (dd/mmm/yyyy)

Spousal Dental Coverage      Does your spouse have dental coverage under his/her own insurance plan?

Yes  No

Effective date (dd/mmm/yyyy)

#### Does your spouse's health/dental plan cover:

Health      Dental

- |                       |                       |                                    |
|-----------------------|-----------------------|------------------------------------|
| <input type="radio"/> | <input type="radio"/> | Your spouse only                   |
| <input type="radio"/> | <input type="radio"/> | Your spouse and yourself only      |
| <input type="radio"/> | <input type="radio"/> | Your spouse and children only      |
| <input type="radio"/> | <input type="radio"/> | Your spouse, you and your children |

Spouse's date of birth (dd/mmm/yyyy)

**6 For Quebec residents  
(age 65 or over)**

- I am participating in the RAMQ drug plan provided by the Quebec government  
 I am NOT participating in the RAMQ drug plan provided by the Quebec government

**7 Family information**

Complete this section **only** if you are required to enrol your spouse and/or dependants.

If more than 4 children, please attach a separate listing.

If requesting family coverage, please ensure your spouse and children are listed below, regardless of whether they have health or dental care coverage under another plan.

Spouse/child name Include last name if different from your last name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Relationship code H/W/S/C (see below)	Full-time student? (Yes or No)
spouse Hryshyna, Yauheniya	19/03/1985	<input type="radio"/> M <input checked="" type="radio"/> F	W	N/A
child Vrekic, Nikola	20/03/2013	<input type="radio"/> M <input checked="" type="radio"/> F	C	<input type="radio"/> Yes <input checked="" type="radio"/> No
child		<input type="radio"/> M		<input type="radio"/> Yes
child		<input type="radio"/> F		<input type="radio"/> No
child		<input type="radio"/> M		<input type="radio"/> Yes
child		<input type="radio"/> F		<input type="radio"/> No

Relationship codes: H = Husband, W = Wife, S = Common-law spouse, C = Child

If a dependant is disabled and over-age, please complete GL0514E, Application for Over-Age Disabled Dependant Coverage.

**8 Beneficiary designation**

For benefits payable upon death, the beneficiary will be **ESTATE**. If you would like to designate a named beneficiary other than "ESTATE", please complete and sign GL1435E, **Beneficiary Designation**.

**9a Direct deposit**

Complete the following section if you would like to sign up for direct deposit of your claim payments.

Name of financial institution

Address (number, street)	City	Province	Postal code
Transit number (5 digits)	Institution number	Bank account number	

<b>Manulife Bank</b> 500 KING ST. NORTH WATERLOO, ONTARIO N2J 4C6 MEMO	The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter.	
108 122 540	00011001111	
Transit number	Institution number	Account number

**9b Electronic claim statement**

By completing the email section, you will be sent an invitation to register for an online member account.

Complete the following section only if your plan offers online services and you wish to enroll for the service.

If the email and banking fields are completed you will receive an electronic claim statement, otherwise you will receive your claim statement by mail.

Email

*milan@voltaeffect.com*  
work email.

**10 Plan member signature**

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("Manulife"). I understand that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). I certify that the information in this form is true and complete to the best of my knowledge. I understand that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependents, in the future is true and complete to the best of our knowledge. I acknowledge and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information.

I authorize Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. I am authorized by my Dependents to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. I authorize my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. I authorize the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. I agree a photocopy or electronic version of this authorization is valid.

If applicable, I authorize Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. I confirm that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative. I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). I also understand and agree that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). I also hereby acknowledge and agree that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, I authorize Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. I understand such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. I agree that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. I agree should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. I understand that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate Information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at [www.manulife.ca/groupbenefits](http://www.manulife.ca/groupbenefits), or from my Plan Sponsor.

Please sign and date here.

Plan member's signature

Date signed (dd/mmm/yyyy)

07/04/2012

**11 Mailing instructions**

Please send the completed form to:

Plan Member Administration  
Manulife Financial  
PO BOX 2026  
HALIFAX NS B3J 2Z1

La version française du document se trouve à l'adresse [www.manuvie.com/assurancecollective](http://www.manuvie.com/assurancecollective).



For your future™

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### 1 Plan sponsor statement

To be completed and signed by plan sponsor.

Enter member's certificate number, if known. Otherwise leave blank for Manulife Financial to complete.

Plan contract number <b>39127</b>	Account/Division number <b>039</b>	Billing division (if applicable)	Plan member certificate number
--------------------------------------	---------------------------------------	----------------------------------	--------------------------------

Plan sponsor name

Volta Labs

Plan sponsor telephone number  
**(902) 292-0970**

Re-hire date (dd/mmm/yyyy)

Provide permanent full time hire date (dd/mmm/yyyy)  
**March 3, 2014**  
If a re-hire, provide the date previous employment ended (dd/mmm/yyyy)

Do you want the waiting period added to the permanent full time hire date?

Yes  No

Plan member's occupation

Programs Director

Class

Regular hrs./week

**X 40**

Annual earnings

**\$ 24,000**

I certify that the plan member listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.

Plan administrator signature

Date signed (dd/mmm/yyyy)

**X 07/04/2014**

In order to determine if evidence of insurability is required, please refer to your contract.

Is evidence of insurability required?  Yes  No

If evidence of insurability is required, plan members must complete GL0004E, Evidence of Insurability, and send it to Manulife Financial for processing. Manulife Financial will not contact your Plan Administrator to verify that this form has been mailed.

### 2 Plan member information

We require this information to enrol you in the plan.

Plan member name (last, first, middle initial) (please print)

Pardoe, Melody

Date of birth (dd/mmm/yyyy)

**05/Feb/1985**

Sex

Male  Female

Province of residence

Nova Scotia

Language of preference

English  French

### 3 Plan member address

Address (number, street, apt. number)

**3516 John Parr Drive**

City

**Halifax**

Province

**NS**

Postal code

**B3K 5V2**

### 4 Applying for coverage

Note: You may refuse benefits for yourself and your dependant(s)/spouse ONLY if you are covered for similar benefits under your spouse's plan. If you wish to add this coverage at a later date you may re-apply for these benefits. Satisfactory medical evidence may be required.

#### Applying for Health and Dental Benefits

Health	Dental
<input checked="" type="radio"/>	<input checked="" type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Myself ONLY

Myself AND 1 dependant/spouse

Myself and 2 or more dependants/spouse

None, because my spouse has coverage

Dependant Life  
  
 Yes  No

Note: If you have eligible dependants, refusal of this benefit is not allowed on an AlphaPlus plan.

Do you have a common-law spouse?

Yes  No

If common-law spouse, provide the date the co-habitation commenced.

Date (dd/mmm/yyyy)

### 5 Coordination of benefits

If you do not have a spouse, this section does not apply.

This information is important for the correct adjudication of your claims.

Spousal Health Coverage Does your spouse have health coverage under his/her own insurance plan?

Yes  No

Effective date (dd/mmm/yyyy)

Spousal Dental Coverage Does your spouse have dental coverage under his/her own insurance plan?

Yes  No

Effective date (dd/mmm/yyyy)

Does your spouse's health/dental plan cover:

Health	Dental	
<input type="radio"/>	<input type="radio"/>	Your spouse only
<input type="radio"/>	<input type="radio"/>	Your spouse and yourself only
<input type="radio"/>	<input type="radio"/>	Your spouse and children only
<input type="radio"/>	<input type="radio"/>	Your spouse, you and your children

Spouse's date of birth (dd/mmm/yyyy)

**6 For Quebec residents  
(age 65 or over)**

- I am participating in the RAMQ drug plan provided by the Quebec government  
 I am NOT participating in the RAMQ drug plan provided by the Quebec government

**7 Family information**

Complete this section **only** if you are required to enrol your spouse and/or dependants.

If more than 4 children, please attach a separate listing.

X

If requesting family coverage, please ensure your spouse and children are listed below, regardless of whether they have health or dental care coverage under another plan.

	Spouse/child name Include last name if different from your last name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Sex (M or F)	Relationship code H/W/S/C (see below)	Full-time student? (Yes or No)
spouse			<input type="radio"/> M <input type="radio"/> F		N/A
child			<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No
child			<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No
child			<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No
child			<input type="radio"/> M <input type="radio"/> F		<input type="radio"/> Yes <input type="radio"/> No

Relationship codes: H = Husband, W = Wife, S = Common-law spouse, C = Child

If a dependant is disabled and over-age, please complete GL0514E, Application for Over-Age Disabled Dependant Coverage.

**8 Beneficiary designation**

For benefits payable upon death, the beneficiary will be **ESTATE**. If you would like to designate a named beneficiary other than "ESTATE", please complete and sign GL1435E, **Beneficiary Designation**.

**9a Direct deposit**

Complete the following section if you would like to sign up for direct deposit of your claim payments.

Name of financial institution

Scotiabank

Address (number, street)

5656 Spring Garden

City

Halifax

Province

NS

Postal code

B3J 1H4

Transit number (5 digits)

80903

Institution number

002

Bank account number

0119989

 Manulife Bank  
500 KING ST. NORTH  
WATERLOO, ONTARIO N2J 4C6

MEMO

108 101122 5401 000110011111

The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter.

Transit number

Institution number

Account number

**9b Electronic claim statement**

By completing the email section, you will be sent an invitation to register for an online member account.

Complete the following section only if your plan offers online services and you wish to enroll for the service.

If the email and banking fields are completed you will receive an electronic claim statement, otherwise you will receive your claim statement by mail.

Email

Melody@voltaeffect.com  
work email.

**10 Plan member signature**

**I** hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife Financial ("Manulife"). **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependents, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information.

**I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I am authorized** by my Dependents to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid.

If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Group Benefits policy ("Policy"), into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me, or my duly authorized representative. **I understand and agree** that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.

**I understand** that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

**I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at [www.manulife.ca/groupbenefits](http://www.manulife.ca/groupbenefits), or from my Plan Sponsor.

Please sign and date here.

Plan member's signature

Date signed (dd/mmm/yyyy)

07/04/2014

**11 Mailing instructions**

Please send the completed form to:

Plan Member Administration  
Manulife Financial  
PO BOX 2026  
HALIFAX NS B3J 2Z1

La version française du document se trouve à l'adresse [www.manuvie.com/assurancecollective](http://www.manuvie.com/assurancecollective).



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## Group Benefits Plan Administrator Internet and Billing Registration

Send this registration form to the address below. Please make sure to include your signed Electronic Administration of Policy Agreement.

If your plan has already arranged access and is actively using the Plan Administrator Site, submit all information changes (including adding or deleting users) to PA Internet Registration:

- By fax to (519) 883-0349
- By mail to Manulife Financial Group Benefits, PA Internet Registration

380 Weber Street N, Waterloo ON N2J 3J3 - Delivery Station GB-A

**Please indicate whether this registration is:**

- Adding a new user. (If the new user replaces an existing user, provide the name and User ID of the person to delete in Section 5, Additional information.)
- Deleting a user. (Provide the name and User ID in Section 5, Additional information.)
- Changing information about a current user/alternate user.

**Please ensure all the sections have been completed, including signatures.**

### 1 Company information

Plan sponsor name	Plan contract number
VOLTA LABS INCORPORATED	39127-039

### 2 Plan administrator/ user information

Please check  if changing any of the following:

- Work mailing address
- Email address
- Access to On-line billing
- Preferred user ID

Enter new information in the appropriate field, if applicable.

Last name of Plan administrator	First name of Plan administrator	Middle initial
Pardee	Melody	J
Language of preference	Sex	Date of birth (dd/mmm/yyyy)
<input checked="" type="radio"/> English <input type="radio"/> French	<input type="radio"/> Male <input checked="" type="radio"/> Female	
Work mailing address (number, street)	City	Province
5415 Spring Garden Rd.	Halifax	NS
Email address (mandatory)	Postal code	
melody@VoltaEffect.com	B3J 1E7	
Access to On-line billing:	<input checked="" type="radio"/> Yes <input type="radio"/> No	
Preferred user ID (Your preferred user ID must be a minimum of 6 characters and a maximum of 20 characters long.)		
VoltaMRM		

### 3 Alternate Plan ? administrator/user information

An alternate user is recommended in the event that the Plan administrator is unavailable or absent for an extended period of time (i.e. vacation, illness, conferences). The alternate user would be able to access the Group Benefits internet site to continue administration for your company on the Plan administrator's behalf.

Please check here if changing information about alternate user. Enter new information below, if applicable.	Middle initial
Last name of alternate user	First name of alternate user
Vrekic	Milan
Language of preference	Date of birth (dd/mmm/yyyy)
<input checked="" type="radio"/> English <input type="radio"/> French	
<input type="radio"/> Male <input checked="" type="radio"/> Female	
Work mailing address (number, street)	City
5415 Spring Garden Rd.	Halifax
Email address (mandatory)	Province
milan@VoltaEffect.com	NS
Postal code	
B3J 1E7	
Access to On-line billing:	<input checked="" type="radio"/> Yes <input type="radio"/> No
Preferred user ID (Your preferred user ID must be a minimum of 6 characters and a maximum of 20 characters long.)	
VoltaMRM	

### 4 User access requirements

Adding numbers

Internet access:	Plan contract number(s)
<input type="radio"/> All plans and accounts/divisions	39127
<input checked="" type="radio"/> Only the following plans and accounts/divisions	039
On-line Bill access:	Account(s)/Division(s)
<input type="radio"/> All plans and accounts/billing divisions	39127
<input checked="" type="radio"/> Only the following plans and accounts/billing divisions	039
Plan contract number(s)	Account(s)/Billing division(s)

Deleting numbers

Plan contract number(s)	Account(s)/Division(s)
-------------------------	------------------------

### 5 Additional information

### 6 Plan sponsor authorization

Please authorize by obtaining the signature of the Policyholder, Plan Sponsor and/or current Plan Administrator.

Print name	Title
Milan Vrekic	Executive Director
Signature	Date signed (dd/mmm/yyyy)



For your future™

## Group Benefits

### Premium Pre-Authorized Debit (PAD)

**When to use this form:** For pre-authorized debit payment of premiums for Group insured and/or Administrative Services Only (ASO) billed in advance financial agreements as calculated by Manulife.

**When not to use this form:** For any benefits with an Administrative Services Only (ASO) billed in arrears financial agreement.

#### 1 Plan sponsor information

Plan sponsor (the "Payor")

VOLTA LABS INCORPORATED  
Plan sponsor/Payor's address (number, street, suite)  
5415 SPRING GARDEN RD. HALIFAX NS  
City or town Province Postal code  
B3J 1G1

Name of person to be contacted

Email address of person to be contacted

Group contract number

39127

All billing divisions

List specific billing division(s) 039

One PAD form is required when PAD is to be drawn from one bank account for all divisions.

A separate PAD form is required for each division, when PAD is to be drawn from different bank accounts.

#### 2 Payor's banking information

New PAD  
Business agreement\*

Change PAD  
Business agreement\*\*

Termination of PAD  
Business agreement\*\*

\*Attach a blank cheque marked "VOID" and complete the banking details below.

\*\*The Launch Plan™ - PAD is the mandatory payment method. Termination of PAD will result in termination of the contract.

PAD pull date

Under 100 lives: The Launch Plan, AlphaPlus and Signature

• PAD pull date will default to the 10<sup>th</sup> of each month. No other date options are available for these products.

Greater than 100 lives: Signature or Corporate

Select PAD pull date  10<sup>th</sup>  20<sup>th</sup>

- If you select 20<sup>th</sup> as your PAD pull date, your bill generation date must be 25<sup>th</sup> or later.
- PAD pull date can be changed upon the renewal of your policy.

Name of financial institution

Royal Bank of Canada

Address

5855 Spring Garden Rd, Halifax, N.S. B3H 4S2

Transit number

03413

Bank number

003

Account number

1028372

NP		VOLTA LABS INCORPORATED 5415 SPRING GARDEN RD HALIFAX NOVA SCOTIA B3J1G1 T: 902 292 0970		DATE 20 Y Y - M M - D D Y Y Y Y M M D D
PAY to the order of				\$ 000117
 <b>ROYAL BANK OF CANADA</b> SPRING GARDEN & SUMMER BRANCH 5855 SPRING GARDEN RD HALIFAX, NOVA SCOTIA B3H 4S2				DOLLARS 100 VOLTA LABS INCORPORATED
RE				PER



1000117 03413 003102837 21

15-

### 3 Acknowledgment

The payor acknowledges that this Authorization is provided for the benefit of the payee, The Manufacturers Life Insurance Company ("Manulife"), and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against the Payor's account set out above (the "Account") in accordance with the rules of the Canadian Payments Association.

1. The Payor acknowledges that provision and delivery of this Authorization to Manulife constitutes delivery by the Payor to the Processing Institution.
2. The Payor certifies that the above banking information is accurate and complete. A specimen cheque marked "void" has been attached to this Authorization. The Payor agrees to inform Manulife in writing of any change in the Account Information 10 days prior to the next due date of the PAD. New PAD Agreements received at Manulife 10 days prior to your next bill run will become effective on the next Group Benefits Billing Statement.
3. The Payor warrants and guarantees that all persons whose signatures are required to sign on this Account have signed this Authorization and that all persons signing this Authorization are authorized signing officers empowered to enter into this agreement.
4. The Payor hereby authorizes Manulife to issue PADs drawn on this Account with the Processing Institution on a monthly basis on or after the 10<sup>th</sup> of each month, or the 20<sup>th</sup> if selected for the following purposes:
  - Payment of premiums for Group Insurance as calculated by Manulife.
 The Payor authorizes the Processing Institution to deal with these withdrawals as if they were signed by the Payor.
5. The Payor and Manulife agree that the amount of the PAD authorized by this Authorization may vary from month to month, according to the amount due on the most recent Billing Statement, as calculated by Manulife in its discretion according to policy administration Information supplied by the Payor. Any payments or adjustments processed after the date prepared on the most recent Billing Statement will be reflected on the next Billing Statement.
6. The Payor acknowledges that the Processing Institution is not required to verify that a PAD has been issued in accordance with this Authorization including, but not limited to, the amount; nor is the Processing Institution required to verify that any purpose of payment for which the PAD was issued has been fulfilled by Manulife.
7. This Authorization may be revoked by the Payor upon 10 days' written notice. If PAD is a mandatory payment method for your Group Contract termination of the PAD will result in termination of the Contract.
  - The Payor may obtain a sample cancellation form, or further information on their right to cancel a PAD Agreement, at their financial institution or by visiting [www.cdnipay.ca](http://www.cdnipay.ca).
8. The Payor has certain recourse rights if any debit does not comply with this agreement. For example, the Payor has the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on recourse rights, the Payor may contact their financial institution or visit [www.cdnipay.ca](http://www.cdnipay.ca).
9. The Payor consents to the disclosure of any personal information contained in this Authorization to Manulife's bank, but only as far as any such disclosure is directly related to and necessary for the proper application and processing of the Pre-Authorized Debit.
10. The Payor acknowledges receipt of a copy of this Authorization, and understanding, acceptance and participation in a PAD plan.

### 4 Signature

Signed at	<i>Hannover, NS</i>	this day of	<i>7/04/2014</i>
Payor	<i>Milan Vrekic</i>		
Name	Per (signature)		
	Title		
	<i>Executive Director</i>		

### 5 How to submit the form

Choose one of two available options.

Email scanned form to: [GRP.CFS.PAD@manulife.com](mailto:GRP.CFS.PAD@manulife.com)

OR

Mail: Premium Administration  
Group Benefits  
Manulife Financial  
PO BOX 1627  
WATERLOO ON N2J 4P4