Manulife Financial

Personal Critical Illness

- **Application**
- **Evidence of Insurability**
- **Payment Information**
- **Certification and Authorization**

Manulife Financial

Group Benefits
Personal Critical Illness Application

Important Note:
Any contract issued with child coverage will contain an exclusion stating that no benefits will be paid for any pre-existing medical conditions, as defined in the contract. Additionally, there will be an exclusion concerning children born within the first ten (10) months of child coverage.

Instructions:
1. If applying for your first time, please provide your group health policy number. If changing coverage please provide your personal benefits certificate number.
2. Please consult your plan administrator for the health policy number and health certificate number, if applicable.
3. Please print in ink.
4. **Please retain a photocopy for your files.**

1a) Plan member information

Required if applying for member, spousal or child coverage

Personal benefits policy number	Personal benefits certificate number	Health policy number	Health certificate number
0010006			

Plan sponsor/employer name

Plan member name (first, middle initial, last)

Sex	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
◯ Male ◯ Female		( )	( )

Email address (optional)	Plan member's address (street number, street and apartment)

City	Province	Postal code

1b) Personal critical illness amount

Required if applying for member coverage

Available in multiples of $5,000 with a minimum $10,000 up to $150,000.

Are you applying for the first time? ◯ Yes ◯ No

If *yes*, amount requested $_____

If *no*, additional amount requested $_____

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

2 Spousal information

Only required if applying for spousal coverage

Spouse's name (first, middle initial, last)	Sex	Date of birth (dd/mmm/yyyy)
	◯ Male ◯ Female	

Spousal critical illness amount

Available in multiples of $5,000 with a minimum $10,000 up to $150,000.

Are you applying for the first time? ◯ Yes ◯ No

If *yes*, amount requested $_____

If *no*, additional amount requested $_____

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

3 Child information

Only required if applying for coverage for child(ren)

Child critical illness amount:

◯ $10,000 benefit applies to all eligible dependent children under age 18.

Provide details for all children under age 18.

Name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)	Sex
		◯ Male ◯ Female
		◯ Male ◯ Female
		◯ Male ◯ Female
		◯ Male ◯ Female
		◯ Male ◯ Female

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Group Benefits
Personal Critical Illness Evidence of Insurability

Conditions for eligibility:
The following questions should be answered by each individual applying for coverage. If more space is needed, use another form or sheet of paper (both must be signed and dated).

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Policy number(s)

Certificate number

Plan member name (first, middle initial, last)

Member ◯ Smoker ◯ Non-smoker

Spouse ◯ Smoker ◯ Non-smoker

1 a) Plan member basic medical information

Height _____ m _____ cm _____ ft _____ in

Weight ◯ kg ◯ lb

Any weight change greater than 10 pounds in the last 12 months? ◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb

Reason: _____

Name of personal physician (first, middle initial, last)

Physician's phone number ( )

Date of last visit (dd/mmm/yyyy)

Reason

Address of personal physician (street number, street and suite)

City

Province

Postal code

1 b) Spouse basic medical information

Height _____ m _____ cm _____ ft _____ in

Weight ◯ kg ◯ lb

Any weight change greater than 10 pounds in the last 12 months? ◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb

Reason: _____

Name of personal physician (first, middle initial, last)

Physician's phone number ( )

Date of last visit (dd/mmm/yyyy)

Reason

Address of personal physician (street number, street and suite)

City

Province

Postal code

2 Medical questionnaire

	Plan member	Spouse
A. **Have you ever had an application for any insurance that was declined, postponed or rated in any way?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Reason

B. **Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment, care or been advised to receive care or have further treatment for:**		
1) AIDS, a positive HIV test or AIDS-related disease?	◯ Yes ◯ No	◯ Yes ◯ No
2) Diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
3) Organ transplant?	◯ Yes ◯ No	◯ Yes ◯ No
4) Hepatitis or hepatitis carrier state, other than Hep A?	◯ Yes ◯ No	◯ Yes ◯ No
5) Stroke or transient ischemic attack (TIA)?	◯ Yes ◯ No	◯ Yes ◯ No
6) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?	◯ Yes ◯ No	◯ Yes ◯ No

2 Medical questionnaire (continued)

	Plan member	Spouse
7) Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congestive heart failure, arrhythmia, peripheral vascular disease, or aneurysm?	◯ Yes ◯ No	◯ Yes ◯ No
8) Chest pain? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause
Diagnosis		Status
Treatment		

9) Congenital heart disorder? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause
Diagnosis		Status
Treatment		

10) Heart murmur, shortness of breath, irregular heart beat, any disorder of the blood? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause
Diagnosis		Status
Treatment		

11) Lymph, glandular disorder, or thyroid disorder? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)
Diagnosis	Status
Treatment	

12) Alcohol or drug abuse? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy) and duration
Treatment and results	

13) Cancer, leukemia, Hodgkin's disease or other malignancy?	◯ Yes ◯ No	◯ Yes ◯ No
14) Growths, cysts or tumour? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Type
Location on body		Status ◯ Benign ◯ Malignant
Treatment		

15) Dysplastic nevi or moles? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Type
Location on body		Status ◯ Benign ◯ Malignant
Treatment		

2 Medical questionnaire (continued)

	Plan member	Spouse
16) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person | Date of onset (dd/mmm/yyyy) | Date of last symptoms (dd/mmm/yyyy)

Diagnosis | Status

Treatment

Name and address of doctor seen

C. 1) **Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, chronic kidney disease, angina, stroke, multiple sclerosis, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60?** If answered yes, please provide details in the chart below.	◯ Yes ◯ No	◯ Yes ◯ No

Member or spouse's family member	Name of family member	Relationship	Condition	Age at onset	Age at death (if applicable)
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					

2) If you have a family history of breast or ovarian cancer, have you had a breast exam, mammogram or other investigation? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person | Date (dd/mmm/yyyy)

Results

3) If you have a family history of colon cancer, have you had a colonoscopy? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person | Date (dd/mmm/yyyy)

Results

D. **During the last 5 years, have you had any abnormal result of any of the following: EKG, stress EKG, echocardiograms, mammogram, Pap smear (exclude if 2 subsequent Pap smears have been normal), PSA, sigmoidoscopy, colonoscopy, biopsy?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person | Test type | Date (dd/mmm/yyyy)

Test results | Status

Treatment

E. **Other than for a common cold, osteoarthritis, bone fractures, have you had an abnormal result of any of the following: X-ray, CAT scan, or MRI?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person | Test type | Date (dd/mmm/yyyy)

Test results | Status

F. **Have you ever had elevated blood pressure or cholesterol?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person | Date (dd/mmm/yyyy)

Most recent results | Is it under control?

Treatment

G. **Are you aware of any symptoms or complaints for which you have not sought treatment or advice, or are you awaiting any tests or test results?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person

Details

Manulife Financial

Group Benefits
Personal Critical Illness Payment Information

Please ensure funds are available at the time of the application as premium is due the 1st of the month following approval and a withdrawal may occur before you receive formal notification.

For verification purposes we require a VOID cheque if a payment is being withdrawn from your financial institution.

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Policy number(s)	Certificate number

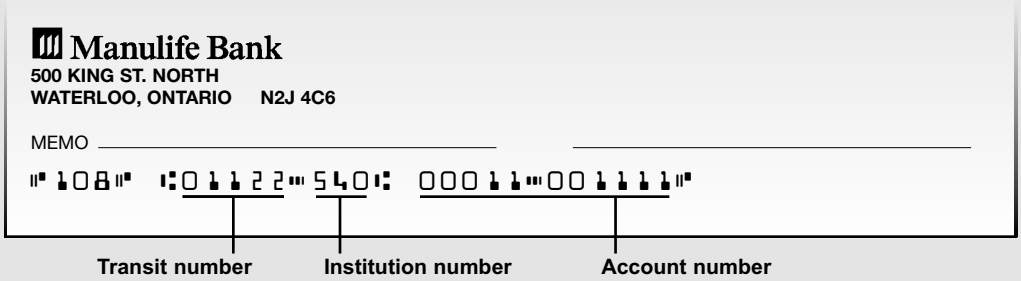
Plan member name (first, middle initial, last)

1 Monthly payment options

Please complete section 1a for Pre-Authorized Collection or 1b for Credit Card Payment.

a) For Pre-Authorized Collection (PAC)

(The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.)



Name of account holder (if other than plan member)

Name of financial institution	Type of account
	◯ Chequing ◯ Non-chequing

Transit number	Institution number	Account number

Joint accounts: Is this a joint account requiring only one signature? ◯ Yes ◯ No

If more than one signature is required on withdrawals issued against the account, both account holders must sign the authorization on page 7 of 7.

Non-chequing accounts: For accounts with no chequing privileges, Manulife requires validation from your financial institution (e.g. withdrawal slip with official stamp) in order to begin the pre-authorized payment process.

b) For credit card payment

Name of account holder (if other than plan member)

Credit card	Account number	Expiry date (mm/yy)
◯ Visa ◯ MasterCard ◯ Amex		

Manulife Financial

Group Benefits
Personal Critical Illness Certification and Authorization

1 Certification and authorization

I certify that I, being the plan member with the capacity to contract, am applying for this personal benefits coverage/insurance ("Coverage") and that all information provided in support of this application is true and complete. **I agree** that my Coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in support of this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information and personal health information including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, relevant to this application ("Information") for the purposes of the assessment, investigation and/or management of this application, including but not limited to medical underwriting; and where Coverage is issued, the administration, audit and management of my Coverage and the investigation of any claims made thereunder, including my participation in any independent medical assessments (collectively, the "Purposes"). **I understand** that I am responsible for any fees related to the completion of this application. Where this application pertains to one of my Dependents (spouse and/or child) **I certify that I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any such Dependants, for the Purposes. **I authorize** any person or organization with Information including, but not limited to, any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other 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 understand** that any Coverage shall not become effective until approved by Manulife.
I hereby authorize the use of my Social Insurance Number ("SIN"), where my SIN is used as my certificate number, for the purposes of identification and administration of this application and any Coverage, and for the facilitation of any pre-authorized collection and credit card billing.

I authorize Manulife to withdraw, until further written notice from me or my duly authorized representative, all premium payments ("Payments") due in relation to the Coverage, either from the bank account identified on the attached void cheque, or from the credit card account I have identified in this application (both referred to herein as the "Account"), whichever is applicable, on or about the first business day of each month in which Coverage premiums are due. **I also understand and agree** that either Manulife or I may, at any time upon written notice, discontinue the direct withdrawal of Payment(s), from my Account, in which case Manulife shall be entitled to require another method of payment, acceptable to Manulife. The terms and conditions of this pre-authorized collection and credit card billing authorization shall apply to the Accounts herein named by me and any other Accounts I choose to name in the future, and shall remain valid for the duration of my Coverage or until revoked by me in writing.

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 yet 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 Information (or other materials related Manulife products and services) from Manulife through the email address identified on this form that I may contact the Customer Service Centre to opt-out of receiving this information.

I agree a photocopy or electronic version of this authorization is valid. **I acknowledge** that Manulife's Privacy Policy is available upon request or at www.manulife.ca

Signature of plan member	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if the Evidence of Insurability has been completed on behalf of the spouse)	Date signed (dd/mmm/yyyy)
Signature of account holder, if different from plan member	Date signed (dd/mmm/yyyy)
Signature of joint account holder (if applicable)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a personal benefits file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

2 Mailing instructions

Please send the completed form to:

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