Manulife Financial

Personal Life

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

Manulife Financial

Group Benefits
Personal Life 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.**

1 a) 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
0010004			

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

1 b) Personal life amount

Required if applying for member coverage

Available in multiples of $25,000 up to $500,000.

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 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

NOTE: This section is to be used to identify beneficiaries for coverage on the plan member only. For spouse and/or dependant coverage, the plan member is automatically the beneficiary, if living, and if not living, the plan member's estate will be the beneficiary.

Name of beneficiary (last, first and middle initial) (please print)	Relationship to plan member	Percentage of benefit
		%
		%
		%
	TOTAL	100%

For designated beneficiaries under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

Irrevocability

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
◯ Revocable ◯ 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. **You are responsible for ensuring the validity of your designation.**

3 Spousal information

Only required if applying for spousal coverage

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

Spousal life amount
Available in multiples of $25,000 up to $500,000.

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

4 Child information

Only required if applying for coverage for child(ren)

Child life amount:
◯ $20,000 benefit applies to all eligible dependent children under age 21.

Please provide the following information for each dependant to be insured.

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

Manulife Financial

Group Benefits
Personal Life Evidence of Insurability

For Manulife Financial use

Policy number(s)	Certificate number

Plan member name (first, middle initial, last)	Member	Spouse
	◯ Smoker ◯ Non-smoker	◯ Smoker ◯ Non-smoker

1 a) Plan member basic medical information

Height	Weight
_____ m _____ cm _____ ft _____ in	◯ kg ◯ lb

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb	Was this a gain or a loss?	Reason

Name of personal physician (first, middle initial, last)	Physician's phone number
	( )

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

City	Province	Postal code

1 b) Spouse basic medical information

Height	Weight
_____ m _____ cm _____ ft _____ in	◯ kg ◯ lb

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb	Was this a gain or a loss?	Reason

Is name of personal physician the same as member? ◯ Yes ◯ No
If "No," please provide:

Name of personal physician (first, middle initial, last)	Physician's phone number
	( )

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

City	Province	Postal code

2 Medical questionnaire

	Plan member	Spouse
1. Have you, within the last three (3) years, had an application for life or health insurance declined, postponed or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you, within the last three (3) years, consulted a physician, or been treated, for high blood pressure, chest pain, heart attack, heart murmur, stroke, cancer, tumour, ulcer, colitis, diabetes, asthma, epilepsy, back pain, nervous or mental illness, an emotional condition, anxiety or depression, urinary tract infection, sexually transmitted disease, alcoholism, drug addiction, or any disease or disorder of the heart, blood, lungs, liver, kidneys, or urine?	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you, within the last three (3) years, been told that you had any immune deficiency disorder, including AIDS or AIDS RELATED COMPLEX (ARC), or any generalized enlargement of your lymph glands, or any test results indicating possible exposure to the AIDS virus (e.g. HIV, HTLV-III, LAV)?	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you had surgery or been hospitalized within the past three years?	◯ Yes ◯ No	◯ Yes ◯ No
5. Have you consulted a physician or other practitioner within the past sixty days and been advised to have further treatment, examination, diagnostic test, or surgery not already performed?	◯ Yes ◯ No	◯ Yes ◯ No
6. Have you, during the last five (5) years had X-rays, Electrocardiograms, blood or other special tests, for other than regular medical checkups, taken or currently on any treatment/medication?	◯ Yes ◯ No	◯ Yes ◯ No
7. Any family history of any inherited or familial disease? (e.g. Huntington's Chorea, diabetes, heart or kidney disease)	◯ Yes ◯ No	◯ Yes ◯ No
8. During the past 12 months have you, your spouse or your dependants: (a) flown as a pilot, student pilot or crew member or have any intention of doing so? (b) ever engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so? Please specify which activity. _____	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ Yes ◯ No

Please provide details below, if you have answered "Yes" to ANY questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

QUESTION NUMBER	NAME OF PERSON (FIRST & MIDDLE)	DETAILS OR NAME OF CONDITION	DATE AND DURATION	TREATMENT AND RESULTS (RECOVERY OR REMAINING EFFECTS)	NAMES AND ADDRESSES OF PHYSICIANS AND HOSPITALS

Manulife Financial

Group Benefits
Personal Life 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

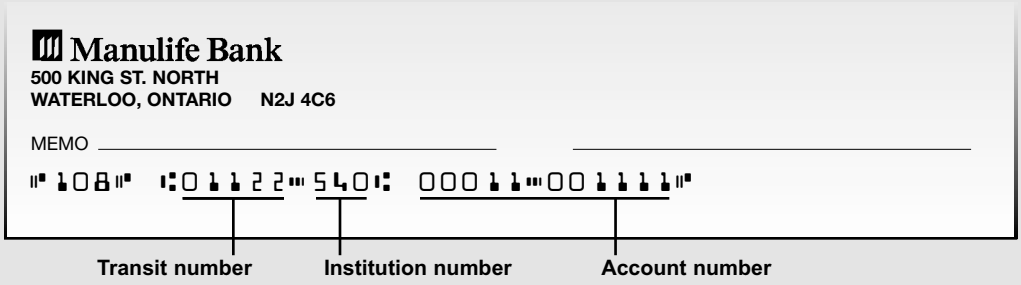
Plan member name (first, middle initial, last)

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 Life 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 designate** the person(s) named under the Beneficiary Designation section, above, as my beneficiary, in the event that the Coverage is issued. **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