

# APPLICATION FOR ALUMNI INSURANCE



The Manufacturers Life Insurance Company

Is the life coverage applied for intended to replace any existing insurance? Yes  No

If yes, indicate the name of the company(ies), the type of coverage being replaced (term, whole life) and the policy number(s).  
If you intend to replace coverage, do not cancel your existing coverage until you receive and review your Alumni contract.

Member

Spouse

Child(ren)

## Member Information

Name	LAST NAME	FIRST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Unit/Apt.#	No./Street	City	Province	Postal Code	
Your Date of Birth (DD/MM/YYYY)		Country of Birth			
Current Occupation (If self-employed, please describe nature of business and duties.)					
E-mail		Tel. (Res.) ( )		(Bus.) ( )	
I am a graduate of (College/University)					

## Spouse Information (Complete only if applying for Spousal Coverage.)

Name	LAST NAME	FIRST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Spouse's Date of Birth (DD/MM/YYYY)		Country of Birth			
Current Occupation (If self-employed, please describe nature of business and duties.)					

## Child Information (Complete only if applying for Child Coverage.)

Last Name	First Name	Date of Birth (DD/MM/YYYY)	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name	Date of Birth (DD/MM/YYYY)	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name	Date of Birth (DD/MM/YYYY)	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name	Date of Birth (DD/MM/YYYY)	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female

If more space is needed, complete a separate sheet, signed and dated.

**ALL PAGES MUST BE COMPLETED.**



Quebec Residents only: After completing the application, you may send Page 3 to Manulife Financial at the address listed on this document.

## Underwriting Questionnaire

Member's Full Name	Home Telephone	Spouse's Full Name	Home Telephone
Member's Physician (Name)	Telephone	Spouse's Physician (Name)	Telephone
Date last seen (DD/MM/YYYY)		Date last seen (DD/MM/YYYY)	
Give reason		Give reason	
Give result		Give result	
Member's Height	Weight	Spouse's Height	Weight

### Has any individual proposed for coverage (member, spouse or child(ren)):

	MEMBER		SPOUSE		CHILD(REN)	
	YES	NO	YES	NO	YES	NO
1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including carrier state), kidney disorder, urinary abnormality, unusual infection or immune system abnormality, or other illness not mentioned? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past 7 years, used drugs for other than medical purposes, been treated for or advised to reduce alcohol or drug use or used marijuana? If yes, give details including applicant's name, drug or alcohol type(s) and date(s) last used: _____ ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had back, neck, hip or knee trouble, been treated for chronic pain or fibromyalgia, had X-rays of spine or joints or been hospitalized or disabled by any injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had any positive test, treatment for or exposure to HIV or AIDS? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the last 2 years, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flus, etc.), been advised to see another doctor or to have surgery or had an abnormal investigation or test result? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever engaged in or intend to engage in, any hazardous sport or activity, e.g., flying (except as a fare-paying passenger on a commercially licensed carrier), racing, scuba diving, climbing, etc.? If yes, give details including applicant's name, activity and dates: _____ ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Smoked cigarettes in the last 12 months? (If no, but other forms of tobacco used, give applicant's name and product types) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever applied for any insurance that was declined, modified or rated? If yes, give details including applicant's name, name of company and reason: _____ .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had his/her driver's licence suspended or been charged with impaired driving? If yes, give details including applicant's name, date, driver's licence number and licensing province: _____ .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does any individual to be insured for coverage plan to reside outside of Canada? If yes, give details including applicant's name, date, where, when, why and for how long? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Female applicants only: a) Are you currently pregnant? If yes, give due date: _____ .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you ever had a miscarriage, preeclampsia, Caesarean section or other complication of pregnancy? If yes, give date and details: _____ .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, please give details below. If additional space is required, use a separate page, signed and dated.

Ques. #	Name	Nature of Disorder	Date and Duration	Result	Attending Physician or Hospital

NOTE: The Insurer may request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV) which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

## Beneficiary Designation

### Beneficiary on Member's Coverage

LAST NAME	FIRST NAME
RELATIONSHIP	

*In Québec, the designation of spouse as beneficiary on this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.*

The Member is automatically the beneficiary on any Child coverage applied for.  
If beneficiary is under the age of 18, please name a Trustee to receive the monies in trust for the beneficiary.

NAME OF TRUSTEE FOR ANY MINOR BENEFICIARY

### Beneficiary on Spousal Coverage<sup>3</sup>

LAST NAME	FIRST NAME
RELATIONSHIP	

*In Québec, the designation of spouse as beneficiary on this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.*

<sup>3</sup>The Member is automatically the beneficiary on any Spousal Coverage, unless otherwise indicated by the Member in writing.  
If beneficiary is under the age of 18, please name a Trustee to receive the monies in trust for the beneficiary.

NAME OF TRUSTEE FOR ANY MINOR BENEFICIARY

## Terms & Conditions *(Please read carefully before signing.)*

**DECLARATION:** I/We hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/We declare that the statements contained in this application, including but not limited to the Underwriting Questionnaire originally attached hereto, are true and complete and, together with any other forms signed by me/us in connection with this application, form the basis for any policy or certificate issued hereunder. I/We have read and understand the exclusions and limitations that apply to the coverage applied for. I/We understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date for Life Insurance is a risk not covered. I/We understand that insurance will take effect on the date my/our properly completed application (including the Underwriting Questionnaire) and the first premium are received by Manulife Financial, subject to the approval of the company's underwriters. I/We understand that any health information must be accurate as at the date the application is signed.

**AUTHORIZATION AND REVOCATION:** Relative to the insurance applied for, I/we, the undersigned person(s) to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the Medical Information Bureau, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency, or other organization, institution or person that has any records or knowledge of me/us or of any member of my/our family to be insured under these plans, or of our health, to give Manulife Financial or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I/We authorize Manulife Financial to consult its existing files for this purpose. I/We authorize Manulife Financial, its subsidiaries, affiliates and agents to use this information to offer me/us their products and services. I/We understand that my/our consent to the use of this information to offer me/us products or services is optional and that if I/we wish to discontinue such use, I/we may call or write to Manulife Financial at the address or telephone number shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/We acknowledge receipt of, and confirm my/our agreement with, the Notice on Exchange of Information and the Notice on Privacy and Confidentiality. I/We declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any policy or certificate issued as a result of this application. I/We understand that this consent may be revoked at any time and that if as a result of such revocation the Insurer is unable to obtain proof of claim, this may result in claims not being paid.

I/We (the Member and Spouse, if applying) hereby designate the individual(s) named as beneficiary to receive the proceeds payable upon my/our death(s).

Les parties ont expressément demandé que la présente entente et les annexes ou documents y afférents soient rédigés en anglais.  
The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

Member's Signature	Signed at (City/Town):	Date
Spouse's Signature (if applying for spousal coverage)	Signed at (City/Town):	Date
Co-Signature (for Pre-Authorized Collection, if required by bank)	Signed at (City/Town):	Date
Agent of Record/Broker (if applicable)		Agent ID.

## Questions about this Plan?

Contact Manulife Financial TOLL-FREE at **1 888 913-6333**

from 8 a.m. to 8 p.m., Monday to Friday ET,

or by e-mail at [am\\_service@manulife.com](mailto:am_service@manulife.com)

or visit [www.manulife.com/infoaffinity](http://www.manulife.com/infoaffinity)

Please return your completed application to:

Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3.

Acadia 26510 001 W0E06	UBC 26015 001 W0E06	Concordia 27814 001 W0E06	Confederation 88605 001 W0E06	Grant MacEwan 97601 001 W0E06	Mt Allison 28809 001 W0E06
OCAD 27307 001 W0E06	SFX 26709 001 W0E06	SAIT 34201 001 W0E06			

# TERM LIFE INSURANCE FOR MEMBERS AND SPOUSES

## Benefits and Premiums

The value of 1 unit is \$35,000 until age 60.

<u>MONTHLY PREMIUM PER \$35,000 UNIT OF TERM LIFE BENEFIT</u>				
Age <sup>2</sup>	Non-Smoker <sup>1</sup>		Standard	
	Male	Female	Male	Female
Under 30	\$2.45	\$1.75	\$3.50	\$2.75
30 to 34	\$2.55	\$2.00	\$4.35	\$3.25
35 to 39	\$3.25	\$2.40	\$5.95	\$4.10
40 to 44	\$4.90	\$3.80	\$9.75	\$6.80
45 to 49	\$7.50	\$5.45	\$14.75	\$9.85
50 to 54	\$11.25	\$8.00	\$21.75	\$14.10
55 to 67 <sup>3</sup>	\$18.50	\$13.00	\$32.50	\$22.50
68 and 69 <sup>3</sup>	NO FURTHER PREMIUMS TO PAY			

Maximum Coverage .....22 units

*RATES ARE SUBJECT TO CHANGE WITHOUT NOTICE.*

<sup>1</sup> Non-Smoker rates are available to people who have not smoked cigarettes in the past 12 months, and who meet Manulife Financial's health standards.

<sup>2</sup> "Age" means the age reached on or immediately before the Policy Anniversary Date. Premiums increase with Age.

<sup>3</sup> From Age 61 through Age 69, coverage decreases by 10% of the original amount each year. Coverage terminates at age 70.

## CHILD LIFE AND ACCIDENT INSURANCE

### Benefits and Premiums

The value of 1 unit is \$5,000 in Life benefits plus \$25,000 in Major Impairment benefits for each eligible child, regardless of how many children you have.

<u>MONTHLY PREMIUM</u>	
<u>PER UNIT</u>	
Covers all your eligible children .....	\$1.50

Maximum Coverage..... 4 units

*RATES ARE SUBJECT TO CHANGE WITHOUT NOTICE.*

**KEEP THIS PAGE FOR REFERENCE AND RECORDS.**

# INCOME PROTECTION DISABILITY INSURANCE FOR MEMBERS

## Benefits and Premiums

The value of 1 unit is \$100 in monthly benefits.

<u>MONTHLY PREMIUM PER \$100 UNIT OF INCOME PROTECTION MONTHLY BENEFITS</u>						
Age <sup>1</sup>	Waiting Period					
	30 Days		120 Days		180 Days	
	Male	Female	Male	Female	Male	Female
Under 30	\$1.10	\$1.15	\$0.85	\$0.85	\$0.80	\$0.80
30 to 34	\$1.25	\$1.55	\$1.00	\$1.15	\$0.90	\$1.05
35 to 39	\$1.50	\$1.85	\$1.15	\$1.40	\$1.05	\$1.25
40 to 44	\$1.85	\$2.65	\$1.55	\$2.20	\$1.50	\$2.10
45 to 49	\$2.80	\$3.65	\$2.20	\$2.85	\$2.10	\$2.70
50 to 54	\$4.10	\$4.45	\$3.35	\$3.65	\$3.30	\$3.60
55 to 59	\$5.65	\$4.65	\$4.60	\$3.80	\$4.55	\$3.75
60 to 64	\$4.95	\$3.85	\$3.85	\$3.05	\$3.80	\$3.00

  

<u>OPTIONAL COST OF LIVING ADJUSTMENT ADDITIONAL MONTHLY PREMIUM FOR EACH \$100 UNIT OF MONTHLY BENEFITS</u>	
Under 45	\$0.30
45 to 64	\$0.65

Maximum Coverage..... 35 units

*RATES ARE SUBJECT TO CHANGE WITHOUT NOTICE.*

<sup>1</sup> "Age" means the age reached on or immediately before the Policy Anniversary Date.

Premiums increase with Age.

# MAJOR ACCIDENT PROTECTION FOR MEMBERS AND SPOUSES

## Benefits and Premiums

The value of 1 unit is \$50,000 in Major Impairment benefits plus \$10,000 in Accidental Death benefits.

<u>MONTHLY PREMIUM PER UNIT</u>	
All ages up to Age 69:	\$1.50

  

<u>BENEFIT PAYMENTS</u>	
Major Accident Impairment	Benefit paid per unit of coverage <sup>1</sup>
Severe brain damage	\$50,000
Total and permanent paralysis	\$50,000
Loss of use of two limbs	\$50,000
Total and permanent loss of sight, speech or hearing	\$50,000
Loss of use of one limb, one hand or one foot	\$25,000
Total and permanent loss of sight in one eye or hearing in one ear	\$25,000
Accidental death	\$10,000

Maximum Coverage..... 6 units

*RATES ARE SUBJECT TO CHANGE WITHOUT NOTICE.*

<sup>1</sup> If more than one Major Accident Impairment results from an injury, the total benefit payment will be limited to a maximum of \$50,000 per unit.

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