

Health Declaration

For prompt and accurate processing of your application, please ensure all questions are answered and complete details provided if required.

Member's Physician _____ () _____ / _____ / _____
 Name Tel. # Date last seen (Day/Month/Year)

Reason for last visit _____ Result of last visit _____

Spouse's Physician _____ () _____ / _____ / _____
 Name Tel. # Date last seen (Day/Month/Year)

Reason for last visit _____ Result of last visit _____

Member's Height _____ Weight _____ Spouse's Height _____ Weight _____

Has any individual proposed for coverage:

- 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?
- Ever been treated for or advised to reduce alcohol or drug use?
- 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?
- Ever had any positive test, treatment for or exposure to HIV or AIDS?
- 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?
- 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?
- Smoked cigarettes or marijuana in the last 12 months? (If other forms of tobacco used, give details.)
- Ever applied for any insurance that was declined, modified or rated?
- Ever had his/her driver's licence suspended or been charged with impaired driving?
 If yes, provide driver's licence number: _____
- Does any individual to be insured for coverage plan to reside outside of Canada?
 If yes, state country and date _____

Member		Spouse		Child(ren)	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "yes" to any of the questions above, give details below. Please use separate page if you require additional space.

Ques. #	Name	Nature of disorder	Duration and date	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 provincial health department if required by law.

Member's Full Name _____ Telephone _____
 (PLEASE PRINT)

Spouse's Full Name _____ Date _____
 (PLEASE PRINT)

Note to Québec residents: If you choose, you may mail the Health Declaration (page 3) separately to Manulife Financial (see address below).

QUESTIONS? Contact **MANULIFE FINANCIAL** toll-free at **1 888 913-6333**
 from 8 a.m. to 8 p.m. ET, Monday to Friday, or by e-mail anytime at: **am_service@manulife.com**
 Please return your signed and completed application form to: **Affinity Markets, Manulife Financial,**
P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3

Terms and 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 Health Declaration 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 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 Health Declaration) and the first premium are received by Manulife Financial, subject to the approval of the company's underwriters. I 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 medical or medically related facility, insurance company, the Medical Information Bureau, 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 facsimile of this authorization shall be as valid as the original.

I/We acknowledge receipt of, and confirm my agreement with, the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY (see brochure). 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.

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.

Is the policy applied for intended to replace any existing insurance? Yes No (If Yes, list below the policy numbers to be replaced and insurer):

The insurer may decline an application which indicates replacement is intended. Member _____ Spouse _____

I (the Member) hereby designate the individual(s) named as beneficiary to receive the proceeds payable upon my or my spouse's death.

Beneficiary on Member's Coverage** _____ Relationship _____
Last name First name

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

Beneficiary on Spousal Coverage _____ Relationship _____
Last name First name

Member's Signature _____ Date _____

Spouse's Signature _____ Date _____
(if applying for spousal coverage)

Co-Signature _____ Date _____
(for Pre-Authorized Collections, if required by bank)

Agent of Record/Broker _____
(if applicable)

Before you send in your application, have you:

- Ensured that the information provided is accurate and complete?
- Reviewed the Terms and Conditions?
- Signed your application where indicated?

Once you have completed and signed your application, send your completed application (along with your cheque payable to The Manufacturers Life Insurance Company, if applicable) to:

Attn: Customer Service
Manulife Financial, Affinity Markets, P.O. Box 4213, Stn A, Toronto, ON M5W 5M3
 or fax to **1-800-510-3362** Attn: Customer Service.
 (Note: If faxing application, please mail your original to the address specified above.)

If you have any questions, please call us toll-free at **1 888 913-6333** Monday to Friday from 8 a.m. to 8 p.m. Eastern Time or e-mail us at **am_service@manulife.com** at any time.

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 ²	Non-Smoker ¹		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 ³	\$18.50	\$13.00	\$32.50	\$22.50
68 and 69 ³	NO FURTHER PREMIUMS TO PAY			

Maximum Coverage22 units

RATES ARE SUBJECT TO CHANGE WITHOUT NOTICE.

¹ 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.

² "Age" means the age reached on or immediately before the Policy Anniversary Date (December 1). Premiums increase with Age.

³ 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 PER UNIT</u>	
Covers all your eligible children	\$1.50

Maximum Coverage 4 units

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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 ¹	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.

¹ "Age" means the age reached on or immediately before the Policy Anniversary Date (December 1). 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 ¹
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

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¹ 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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