Application Form – CA Select™ Insurance Plans

CA Chartered Accountants of Ontario — Manulife Financial

You can apply online at www.icao.on.ca/CArequest for all coverage options available through the CA Select Insurance Plans, including Critical Illness Insurance.

Eligibility

Applicant must be a resident of Canada or Bermuda and a Member of at least one of the Institutes of Chartered Accountants of Ontario, Newfoundland, Prince Edward Island, New Brunswick, Nova Scotia or Bermuda, in order to be eligible to apply for new or additional coverage and must continue membership to maintain this coverage once accepted.

When applying for coverage, please complete all information requested below.
Please complete Member information, even if you are not applying for Member coverage.

MEMBER

Last	First	Initial	❑ MALE ❑ FEMALE ❑ NON-SMOKER† ❑ SMOKER

Unit/Apt.#	No./Street	City	Province	Postal Code

Telephone Number (Residence) ( )	Telephone Number (Business) ( )	E-mail Address

Member's Date of Birth DD/MM/YYYY	Birth Country
Membership Number	

Applicant is a member of The Institute of Chartered Accountants of:

❑ Ontario ❑ New Brunswick ❑ Newfoundland
❑ Prince Edward Island ❑ Nova Scotia ❑ Bermuda

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

Beneficiary on Member's Term Life Coverage*	Last	First	Initial	Relationship

***** In Québec, the designation of spouse on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary. ❑ If more than one beneficiary has been designated, proceeds will be paid in equal shares.***

SPOUSE

Last	First	Initial	❑ MALE ❑ FEMALE ❑ NON-SMOKER† ❑ SMOKER

Spouse's Date of Birth DD/MM/YYYY	Birth Country	Spouse's Occupation (If self-employed, describe nature of your business.)

Beneficiary on Spouse's Coverage**	Last	First	Initial	Relationship

***** The Member is the beneficiary for spouse coverage unless the Member indicates otherwise.***

† Non-smoker rates apply to people who have not used tobacco or tobacco cessation products in the past 12 months and who meet Manulife Financial's health standards.

Child *(Complete only if applying for Child Coverage, and complete only height and weight if applying for more than one unit.)*

Name of Child	Gender ❑ MALE ❑ FEMALE	Date of Birth DD/MM/YYYY	Height ft/in cm	Weight lbs kg	Name and Address of Family Doctor

If applying for more than one child, please complete a separate page, signed and dated

BENEFITS APPLIED FOR AT THIS TIME *(Do not include any existing insurance coverage.)* ❑ New Coverage ❑ Additional Coverage Certificate #________ *(if currently insured)*

If applying for coverage of: **$250,000 to $725,000** your rates will be **10% lower** Just multiply by **.9** in the blue box provided.

If applying for coverage of: **$750,000 to $1,225,000** your rates will be **15% lower** Just multiply by **.85** in the blue box provided.

If applying for coverage of: **$1,250,000 to $2,000,000** your rates will be **18% lower** Just multiply by **.82** in the blue box provided.

Benefit	No. of Units	Monthly premium per unit	Multiplier	
Member Term Life 80 units available		x $	x	= $
Optional Future Insurability Option (FIO) ❑ MALE ❑ FEMALE — The FIO amount available is $25,000 (one unit) or $50,000 (two units). The FIO is available when you apply for Member and/or Spouse Term Life insurance. This option cannot be added to existing Member and/or Spouse Term Life coverage.		x $		= $
Spouse Term Life 80 units available		x $	x	= $
Optional Future Insurability Option (FIO) ❑ MALE ❑ FEMALE — The FIO amount available is $25,000 (one unit) or $50,000 (two units). The FIO is available when you apply for Member and/or Spouse Term Life insurance. This option cannot be added to existing Member and/or Spouse Term Life coverage.		x $		= $
Child Life & Accident Insurance — 5 units available for children 15 days and older, only if you participate in the Member Term Life Plan. (The monthly premium covers all your eligible children.) Coverage for children 0 to 14 days is limited to $5,000 of Life Insurance.		x $ $2.50		= $
Member Income Protection — Minimum 5 Units*/Maximum 150 Units* Waiting Period ___ days ❑ Add Own Occupation Option to all Income Protection coverage applied for		x $	x	= $
Optional Future Insurability Option (FIO) ❑ Male ❑ Female — Maximum total options available is equal to 25% of the Member Income Protection approved and in force, or $2,000. The FIO is only available when you apply for new or additional units of Member Income Protection insurance.		x $		= $
Office Overhead Expense Insurance (Minimum 1 unit of $100) — Maximum 100 Units* Waiting Period ___ days Maximum Benefit Period ___ months. Add Own Occupation Option to all Office Overhead Expense coverage applied for? ❑ Yes ❑ No		x $	x	= $
Member Personal Accident Insurance — 20 units available, only if you participate in the Term Life or Income Protection Plans.		x $ $0.88		= $
Spouse Personal Accident Insurance — 10 units available, only if you participate in the Spouse Term Life Plan.		x $ $0.88		= $

> If applying for Optional Own Occupation Coverage, multiply by **1.20** in the blue box provided. **The option premium is 20% of the new and existing Income Protection coverage premium.**

> If applying for Optional Own Occupation Coverage, multiply by **1.15** in the blue box provided. **The option premium is 15% of the new and existing Office Overhead Expense coverage premium.**

TOTAL MONTHLY PREMIUM = $

* One Unit = $100 Monthly Benefit
> For details on applying for the Own Occupation Option for existing Income Protection and Office Overhead Insurance, refer to the Income Protection and Office Overhead sections in CA Select.

HEALTH DECLARATION

Note to Québec residents: If you choose, you may mail the Health Declaration (pages 2 and 3) directly to Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, ON M5W 5M3.

Member	
Member's Full Name	Telephone
Member's Physician (Name)	Telephone
Physician's Address	
Date last seen: DD MM YYYY	Reason last seen:
Tests, treatment, medication prescribed (If none,state "None"):	
Results and current status:	
Member's Height ft/in cm	Weight lbs kg
Has your weight changed in the past year? ❑ Yes ❑ No If yes:	Gained _____ lbs/kg Lost _____ lbs/kg
Reason for change:	

Spouse	
Spouse's Full Name	Telephone
Spouse's Physician (Name)	Telephone
Physician's Address	
Date last seen: DD MM YYYY	Reason last seen:
Tests, treatment, medication prescribed (If none,state "None"):	
Results and current status:	
Spouse's Height ft/in cm	Weight lbs kg
Has your weight changed in the past year? ❑ Yes ❑ No If yes:	Gained _____ lbs/kg Lost _____ lbs/kg
Reason for change:	

Please complete the following if Child Life Coverage applied for:

Name of Child	Gender	Date of Birth	Height	Weight	Name and Address of Family Doctor
	❑ M ❑ F	DD MM YYYY	ft/in cm	lbs kg	
	❑ M ❑ F	DD MM YYYY	ft/in cm	lbs kg	

If applying for more than two children, please complete a separate signed and dated page.

Please ensure all questions are answered and details provided for all individuals applying for coverage (member, spouse and children). If you require additional space, please use a separate page, signed and dated.

¥ ***If you are applying for only one unit of Child Life and Accident Insurance, you are not required to answer these medical questions for the child(ren).***
If you are only applying for Personal Accident you are not required to complete these medical questions.

Has any individual applying for coverage (member, spouse, child(ren)):	Member YES	Member NO	Spouse YES	Spouse NO	Child(ren)¥ YES	Child(ren)¥ NO
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including name of applicant, date, name of company and reason:	❑	❑	❑	❑	❑	❑
2. a) Had more than 2 driving violations in the past 2 years?	❑	❑	❑	❑	❑	❑
b) Have you ever been charged with impaired driving or had your license suspected?	❑	❑	❑	❑	❑	❑
If yes, give details including name of applicant, nature of offence(s), date(s), Driver's License # and Licensing province:						
3. Have any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including name of applicant, type of activity and date(s):	❑	❑	❑	❑	❑	❑
4. Within the next 12 months, have any intention of travelling or residing outside North America? If yes, state country, departure date, duration and reason.	❑	❑	❑	❑	❑	❑
5. Within the past 10 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? If yes, give details including name of applicant, drug or alcohol type(s) and date(s) last used:	❑	❑	❑	❑	❑	❑
6. Adult female applicants only: a) Are you currently pregnant? If yes, give due date:	❑	❑	❑	❑		
b) Have you ever had a miscarriage, preeclampsia, caesarean section or other complication of pregnancy? If yes, give date and details:	❑	❑	❑	❑		
7. Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned?	❑	❑	❑	❑	❑	❑

Has any individual applying for coverage (member, spouse, child(ren)):	Member YES	Member NO	Spouse YES	Spouse NO	Child(ren)¥ YES	Child(ren)¥ NO
8. Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc.), arthritis, paralysis or weakness, fibromyalgia or chronic pain, had x-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks?	❏	❏	❏	❏	❏	❏
9. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?	❏	❏	❏	❏	❏	❏
10. Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.), been advised to undergo further investigation, see another doctor or have surgery?	❏	❏	❏	❏	❏	❏

If you have answered "yes" to any of the above questions, please provide details below.
If you require additional space, please use a separate page, signed and dated.

Question #: Name of person to be insured:
Nature of disorder:
Date and duration:
Result:
Attending physician or hospital:

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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.

	Member YES	Member NO	Spouse YES	Spouse NO	Child(ren)¥ YES	Child(ren)¥ NO
11. Have any of your parents, brothers or sisters had heart disease, diabetes, cancer, stroke, high blood pressure, kidney disease, hepatitis, Huntington's Chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease or genetic disorder? If yes, complete the following:	❏	❏	❏	❏	❏	❏

Applicant's Name	Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause

COMPLETE THIS SECTION WHEN APPLYING FOR INCOME PROTECTION AND/OR OFFICE OVERHEAD EXPENSE INSURANCE

A. Employment Status: ❏ Employee ❏ Self Employed

If self-employed, what is the organization structure of your business? ❏ Sole Proprietor ❏ Partnership ❏ Corporation

If owner of a partnership or corporation, give percentage ownership: ______ % Date you became self-employed: ______

Complete only if applying for Office Overhead Expense Insurance

Your share of Average Monthly Overhead Expenses (not including salary paid to yourself): $ ______

Have you declared or are you contemplating personal or business bankruptcy? ❏ Yes ❏ No If yes, provide details including date of discharge:

______

Proof of Income: If applying for more than $10,000 a month total disability income protection coverage (applied for and existing) please submit pages 1, 2 and 3 of your last 2 years tax returns. If incorporated, please also submit your last corporate financial statement.

B. Will any income be continued during disability by your employer or as a result of a partnership agreement? ❏ Yes ❏ No

If "yes", what percentage? ______ % For how many months? ______

FINANCIAL INFORMATION *(Complete only if applying for Income Protection Disability Insurance and/or more than $250,000 of Term Life Insurance)*

Member Annual Net Income, after expenses but before tax $________________
Personal Net Worth (assets less liabilities) $______________________

Spouse Annual Net Income, after expenses but before tax $________________
Personal Net Worth (assets less liabilities) $______________________

PAYMENT METHOD

❏ **Annual†**

$	x	†	+	††	=	$
Total Monthly Premium		No. of months to June 1st (excluding present month)		Provincial Sales Tax if applicable		**AMOUNT PAYABLE**

a) ❏ My cheque is enclosed, made payable to "Manulife Financial"

OR

b) ❏ Charge my: ❏ VISA ❏ MasterCard ❏ AMERICAN EXPRESS

Card No. Expiry Date

❏ **Monthly**

$	+	††	=	$
Total Monthly Premium		Provincial Sales Tax if applicable		**MONTHLY AMOUNT PAYABLE**

a) ❏ By Pre-Authorized Collections Plan (PAC). Enclose a sample cheque marked "VOID"

OR

b) ❏ Charge my: ❏ VISA ❏ MasterCard ❏ AMERICAN EXPRESS

Card No. Expiry Date

I authorize Manulife Financial to make a monthly withdrawal from the account described on the accompanying specimen cheque for monthly insurance premiums due on or after the date of this authorization. The Pre-Authorized Collections Plan may be terminated by either the Company or by me through written notice. The Company also reserves the option to change the method of payment for another qualifying option after the occurrence of a payment not honoured.

For your convenience, if you choose payment by PAC or Credit Card, your future premium billings will automatically reflect the same payment method. Please contact us by telephone or e-mail prior to your premium due date, if you'd like to change your method of payment.

Insurance will take effect on the date the completed application and the required premium are received by Manulife Financial, subject to the approval of the Company's underwriters. Once you are approved, you will receive a certificate specifying the coverage provided and outlining the main policy provisions. If you are not insurable, a full refund of the premium will be made.

† Premiums are payable once a year on the Policy Anniversary Date of June 1st. †† Residents of Ontario add 8% Provincial Sales Tax. Residents of Québec add 9% Provincial Sales Tax.

OTHER INSURANCE INFORMATION

Do you (Member or Spouse) have any pending or existing life, disability or overhead expense insurance coverage with Manulife Financial or any other company?
❏ Yes ❏ No If "Yes", please complete the following:

Name of Applicant	Company Name	Type of Insurance (life, disability, office overhead, group LTD)	Coverage Amount	Waiting Period (for disability)	Benefit Period (for disability)	Taxable? (for disability)	Do you intend to replace this coverage?
			$			❏ Yes ❏ No	❏ Yes ❏ No
			$			❏ Yes ❏ No	❏ Yes ❏ No

BENEFICIARY SECTION

Member Beneficiary

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

Last First Initial Relationship

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

Spouse Beneficiary – Beneficiary on Spouse's Coverage††

Last First Initial Relationship

†† ***The Member is the beneficiary for spouse coverage unless the Member indicates otherwise.***

TERMS AND CONDITIONS – *PLEASE READ CAREFULLY BEFORE SIGNING.*

I (the Member) 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 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 is a risk not covered under the Term Life Plan. I/we have read and understand that there are exclusions and limitations on the coverage applied for. 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 and agree that if I am no longer a member of at least one of the Institutes of Chartered Accountants of Ontario, Newfoundland, Prince Edward Island, New Brunswick, Nova Scotia or Bermuda, for any reason whatsoever, my (and, if applicable, my spouse's and children's) insurance coverage under these Plans will be terminated. I understand that it is my responsibility to inform Manulife Financial if my membership in the Institute terminates.**

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 group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me/us or my/our health or the health of any member of my/our family to be insured under this plan to provide to 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 to hold a personal file about myself, my spouse and or child(ren) and my insurance coverage. Further, I/we authorize Manulife Financial, the Policyholder and its authorized staff, as well as its agents, representatives, and advisors to use the information collected as required in the financial management, administration and payment of insurance benefits. I/we authorize Manulife Financial, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me/us their products or services. I/we understand that my/our consent to the use of such 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 telephone number or address shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

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

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

❏ 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.

If you intend to replace coverage, don't cancel your existing coverage until you receive and review your Manulife contract(s).

Member's Signature	Date DD/MM/YYYY	Signed at	Co-Signature *(for Pre-Authorized Collections, if required by bank)*	Date DD/MM/YYYY	Signed at
Spouse's Signature *(if applying for spousal coverage)*	Date DD/MM/YYYY	Signed at	QUESTIONS? Contact Manulife Financial toll-free at **1 866 219-4245** or by e-mail at **am_service@manulife.com**		

Please return your completed application using the enclosed business reply envelope and mail to: Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, ON M5W 5M3

Underwritten by The Manufacturers Life Insurance Company (Manulife Financial)