



The Canadian
Real Estate
Association

APPLICATION FOR REALTOR GROUP INSURANCE PLANS

Underwritten by



The Manufacturers Life Insurance Company

manulife.com/realtor

Member Information *(Please print.)*

Last Name	First	Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	Province
Date of Birth <i>DD/MM/YYYY</i>		Country of Birth	
E-mail		Tel. (Home)	(Bus.)
Occupation	Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If yes, please describe the nature of your business and duties in the space provided above.</i>

Spouse Information *(Complete only if applying for Spouse Term Life Coverage.)*

Last Name	First	Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	Province
Date of Birth <i>DD/MM/YYYY</i>		Country of Birth	
E-mail		Tel. (Home)	(Bus.)
Occupation	Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If yes, please describe the nature of your business and duties in the space provided above.</i>

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

Name of Child	Gender	Date of Birth	Height	Weight	Name and Address of Family Doctor
	<input type="checkbox"/> M <input type="checkbox"/> F	<i>DD/MM/YYYY</i>	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kg	
	<input type="checkbox"/> M <input type="checkbox"/> F	<i>DD/MM/YYYY</i>	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kg	

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

Other Insurance Information

Do you (Member or Spouse) have any existing 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)	Amount	Elimination Period (for disability)	Benefit Period (for disability)	Non-taxable or taxable? (for disability)	Do you intend to replace this coverage?
			\$				<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$				<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$				<input type="checkbox"/> Yes <input type="checkbox"/> No

If you intend to replace coverage, do not cancel your existing coverage until you receive and review your contract. Manulife Financial may decline an application which indicates replacement is intended.

FOR OFFICE USE ONLY:

Insurance Plan Choices

I am applying for New coverage. Additional coverage. If currently insured under these plans, list Policy/Certificate No. _____
If applying for additional coverage, DO NOT INCLUDE COVERAGE ALREADY IN FORCE.

Member: Non-Smoker¹ Smoker

Spouse: Non-Smoker¹ Smoker

¹ Non-Smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife Financial's health standards.

TERM LIFE INSURANCE² (12% VOLUME DISCOUNT ON \$250,000 OR MORE)

<input type="checkbox"/> Member
Amount of coverage applied for \$ _____
Available from \$50,000 to \$750,000 in increments of \$50,000.

<input type="checkbox"/> Spouse
Amount of coverage applied for \$ _____
Available from \$50,000 to \$750,000 in increments of \$50,000.

² Manulife Financial reserves the right to request additional medical information in order to assess your application and also reserves the right to accept or decline applications.

Child Coverage

Available if you participate in the Member Term Life plan (\$2.25 a month covers all your eligible children for \$10,000 of life coverage each.)

Member Income Protection Disability Insurance Plan A Plan B

Available if you participate in the Member Term Life plan.

Number of Units _____ (1 unit = \$100 monthly benefit) Available from 5 units (\$500 monthly benefit) to 50 units (\$5,000 monthly benefit).

Waiting period 60 days 90 days 120 days

Optional - Cost of Living Adjustment (Plan B Only)

If selected, it will be added to all Member Income Protection Disability coverage.

Personal Accident Insurance Member Family

Available if you participate in Term Life Insurance or Member Income Protection Disability Insurance.

Number of Units _____ Available from 1 unit (\$50,000 of coverage) to 5 units (\$250,000 of coverage).

EXTENDED HEALTH CARE (EHC) BENEFITS EHC EHC & Dental

Member

Spouse Available if you participate in Member EHC.

Child Available if you participate in Member EHC.

Check
manulife.com/realtor
for Rates

Financial Information (Complete if applying for more than \$250,000 of Term Life coverage or if applying for Member Income Protection Disability Insurance.)

Member Annual Net Income, after expenses but before tax \$ _____	Spouse Annual Net Income, after expenses but before tax \$ _____
Personal Net Worth (assets less liabilities) \$ _____	Personal Net Worth (assets less liabilities) \$ _____

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 that there are exclusions and limitations on 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, 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 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 (the member) hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any policy or certificate issued hereunder.

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 DD/MM/YYYY _____
Spouse's Signature (If applying for Spouse coverage) _____	Signed at (City/Town) _____	Date DD/MM/YYYY _____
Representative's Name (If applicable.) _____	Code # _____	Date DD/MM/YYYY _____

Complete this section when applying for Member Income Protection Disability Insurance (Member only)

1. If self-employed, what is the organizational structure of your business? Sole Proprietor Partnership Corporation
2. If owner of a partnership or corporation, give percentage ownership: _____ %
3. Date you became self-employed: _____ DD/MM/YYYY
4. 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 \$3,500/month, please submit pages 1, 2 and 3 of your last 2 years' tax returns. If incorporated, please also submit your last corporate financial statement.

Beneficiary Designation for Life Insurance

Beneficiary of Member's Coverage

Last Name	First
Relationship	

In Québec, the designation of spouse as beneficiary of this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.
 The Member is automatically the beneficiary of any Child coverage applied for.
 If the 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 of Spouse Coverage

Last Name	First
Relationship	

In Québec, the designation of spouse as beneficiary of this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.
 The Member is automatically the beneficiary of any Spouse coverage, unless otherwise indicated by the Member in writing.
 If the 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

Québec residents only: After completion you **may** detach this section and send it directly to Manulife Financial at the address shown on this document.

This application is not valid unless the Underwriting Questionnaire is fully completed and the application is signed.

Underwriting Questionnaire (Both sides MUST be completed, even if all health questions are answered "NO".)

Member's Full Name	Home Telephone	Spouse's Full Name	Home Telephone
Member's E-mail Address		Spouse's E-mail Address	
Member's Physician (Name)	Telephone	Spouse's Physician (Name)	Telephone
Physician's Address		Physician's Address	
Date Last Seen DD/MM/YYYY		Date Last Seen DD/MM/YYYY	
Reason		Reason	
Member's Height <input type="checkbox"/> ft/in <input type="checkbox"/> cm	Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg	Spouse's Height <input type="checkbox"/> ft/in <input type="checkbox"/> cm	Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg

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

	MEMBER		SPOUSE		CHILD(REN)	
	YES	NO	YES	NO	YES	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: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 5 years, had their driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), driver's licence no. and licensing province: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Any intention to pilot an aircraft or participate 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): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the next 12 months, any intention of travelling or residing outside North America? If yes, give details including name of applicant, 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"/>
5. Within the past 7 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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. 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"/>		
b) Have you ever had a miscarriage, pre-eclampsia, 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"/>		

