Manulife Financial

CRITICAL ILLNESS INSURANCE APPLICATION

IMPORTANT NOTICE

Before applying for Critical Illness Insurance, it is important to understand that ***this plan is not available*** *to you if you have had or have any of the following conditions or procedures:*

- *Active hepatitis*
- *AIDS or AIDS-related disease*
- *Alcohol abuse in the past five years*
- *Alzheimer's disease*
- *Any heart condition or heart trouble (excluding controlled hypertension)*
- *Cancer – all cancer except basal cell skin cancer*
- *Coronary bypass surgery*
- *Diabetes*
- *Heart attack*
- *Huntington's chorea*
- *Kidney disease – other than kidney stones or a history of kidney infection*
- *Lou Gehrig's disease – amyotrophic lateral sclerosis (ALS)*
- *Major organ transplant (recipient)*
- *Multiple sclerosis*
- *Permanent paralysis (paraplegia, quadriplegia) – other than Bell's palsy*
- *Pulmonary fibrosis*
- *Stroke – cerebrovascular accident*

1. MEMBER INFORMATION ☐ Male ☐ Female

Name (Please Print) Last First

Eligibility: Alumni of the participating schools are eligible to apply. All applicants must be resident in Canada and less than 66 years of age.

Telephone (Residence) ( )

Telephone (Business) ( )

E-mail Address

Address

Unit/Apt.#

City

Province

Postal Code

Date of Birth D D M M Y Y Y Y

Country of Birth

Current Occupation

I am a graduate of:

2. SPOUSE INFORMATION *(if applying for coverage)* ☐ Male ☐ Female

Name (Please Print) Last First

Telephone (Business) ( )

Date of Birth D D M M Y Y Y Y

Country of Birth

Current Occupation

E-mail Address†

3. HOW MUCH INSURANCE ARE YOU APPLYING FOR?

Member ☐ Smoker ☐ Non-Smoker*

a) Do you have any Critical Illness insurance in force or pending with another company? ☐ Yes ☐ No

If yes, total amount

Date issued or applied for

b) Indicate the amount of coverage you require in $25,000 increments.

☐ **$25,000** ☐ **$50,000** ☐ **$75,000** ☐ **$100,000** ☐ **Other (please specify)**

$__________ ,000

COVERAGE AMOUNT

10 % savings on $125,000 or more

Spouse ☐ Smoker ☐ Non-Smoker*

a) Do you have any Critical Illness insurance in force or pending with another company? ☐ Yes ☐ No

If yes, total amount

Date issued or applied for

b) Indicate the amount of coverage you require in $25,000 increments.

☐ **$25,000** ☐ **$50,000** ☐ **$75,000** ☐ **$100,000** ☐ **Other (please specify)**

$__________ ,000

COVERAGE AMOUNT

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

4. PAYMENT METHOD (Please check ✔ only one.)

Option #1

CREDIT CARD: ☐ **MasterCard** ☐ **VISA** **Monthly** ☐ **or Annually** ☐

Credit Card No. ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐

Expiry Date ☐☐☐☐

Option #2

MONTHLY ☐

(BY PRE-AUTHORIZED COLLECTIONS (PAC)).

Enclose a sample cheque marked "VOID".

Option #3

ANNUALLY ☐

(BY CHEQUE, payable to Manulife Financial).

All Applicants : This application is not valid unless the "Declaration of Insurability" section is properly completed and the application is signed and dated.
Québec Residents : After completion, you **may** detach this section and send it directly to the insurance company.

Member Name (Please Print) Last First | **Telephone** (Residence)

5. DECLARATION OF INSURABILITY

1. Member

Height ☐ m/ft ☐ cm/in Weight ☐ kg/lb

Any weight changes in the past 12 months? ☐ Yes ☐ No Indicate amount of change, if any ☐ kg/lb

Loss ☐ Gain ☐ Reason:

2. Member

A. Name and Address of your Regular Attending Physician:

B. Date and reason last consulted: Date :

Reason:

C. Diagnosis, treatment given or medication prescribed:

1. Spouse

Height ☐ m/ft ☐ cm/in Weight ☐ kg/lb

Any weight changes in the past 12 months? ☐ Yes ☐ No Indicate amount of change, if any ☐ kg/lb

Loss ☐ Gain ☐ Reason:

2. Spouse

A. Name and Address of your Regular Attending Physician:

B. Date and reason last consulted: Date :

Reason:

C. Diagnosis, treatment given or medication prescribed:

Question	MEMBER		SPOUSE	
3. Have you ever had any insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes	☐ No	☐ Yes	☐ No

If you answered "Yes", please provide details below.

Name of person to be insured	Details *(If you need more space, please complete on a separate sheet of paper and sign and date it.)*

4. Have you ever:

Question	MEMBER		SPOUSE	
A. Consulted any physician, psychiatrist or other health care professional or been admitted to any hospital or similar institution other than for routine physicals or minor conditions (such as colds, flus, etc.)?	☐ Yes	☐ No	☐ Yes	☐ No
B. Had any symptoms or adverse findings or were you advised to have further examinations, diagnostic tests, hospitalization or surgery not yet done?	☐ Yes	☐ No	☐ Yes	☐ No
C. a) Have you ever had an abnormal EKG?	☐ Yes	☐ No	☐ Yes	☐ No
b) In the past 5 years, have you had any abnormal examination, X-ray, blood test or other diagnostic test?	☐ Yes	☐ No	☐ Yes	☐ No
D. In the past 5 years, have you had any surgical operation, treatment, special diet, illness or injury?	☐ Yes	☐ No	☐ Yes	☐ No
5. A. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	☐ Yes	☐ No	☐ Yes	☐ No
B. Are you receiving any treatment or taking any medication at the present time?	☐ Yes	☐ No	☐ Yes	☐ No
6. Have you ever had or been treated for any disease or disorder of:				
A. The heart or blood vessels, such as heart murmur, heart palpitations, heart disease, heart attack, angina, chest pain, circulatory problems, phlebitis, stroke, transient ischemic attack (TIA), high blood pressure, high cholesterol, or any other disorder of the heart or circulatory system?	☐ Yes	☐ No	☐ Yes	☐ No
B. The chest, lungs, nose, or throat, such as asthma, chronic bronchitis, emphysema, loss of speech, or any other chronic lung or respiratory disorder?	☐ Yes	☐ No	☐ Yes	☐ No
C. The digestive system, including stomach, intestines, liver or pancreas, such as ulcer, colitis, bleeding or hepatitis, including carrier state?	☐ Yes	☐ No	☐ Yes	☐ No
D. The kidneys, bladder, reproductive organs or prostate?	☐ Yes	☐ No	☐ Yes	☐ No
E. The nervous system, such as dizziness, headaches, seizure, paralysis, epilepsy, Parkinson's, Alzheimer's, motor neuron disease (ALS or Lou Gehrig's disease); or any other disease or disorder?	☐ Yes	☐ No	☐ Yes	☐ No
F. The glandular system or blood, such as diabetes, anemia, leukemia or other disease or disorder of the blood or glandular system?	☐ Yes	☐ No	☐ Yes	☐ No
G. The immune system, persistent lymph gland enlargement, unusual infections, any other immune system abnormality or had a positive test related to HIV or been diagnosed with AIDS?	☐ Yes	☐ No	☐ Yes	☐ No
H. The breast, including lumps, cysts, unusual discharge, other physical changes, abnormal mammogram finding or biopsy?	☐ Yes	☐ No	☐ Yes	☐ No
I. Cancer, tumour, polyp, mole, lump or other growth, any disorder of the skin or lymph glands, blood disorder or other form of malignant disease?	☐ Yes	☐ No	☐ Yes	☐ No
7. Have you ever had or been treated for an illness, disease, operation, injury or congenital defect not listed above or do you have any symptoms or complaints for which you have not yet consulted a physician?	☐ Yes	☐ No	☐ Yes	☐ No
8. A. Within the last two years, have you had your driver's licence suspended or had two or more moving violations?	☐ Yes	☐ No	☐ Yes	☐ No
B. Have you used marijuana or taken drugs for other than medical purposes or been advised to reduce alcohol consumption or received treatment for drug or alcohol use?	☐ Yes	☐ No	☐ Yes	☐ No
C. Have you smoked cigarettes in the past 12 months?	☐ Yes	☐ No	☐ Yes	☐ No

If other forms of tobacco used, please give details. Member: Spouse:

Question	MEMBER		SPOUSE	
9. Have any of your immediate family members (father, mother, brother(s) and sister(s)) had heart disease, stroke, hypertension, aneurysm, cancer (specify type), diabetes, kidney disease or any other hereditary disorder? If yes, please provide details.	☐ Yes	☐ No	☐ Yes	☐ No
10. Does any individual to be insured for coverage plan to reside outside of Canada? If yes, state country and date.	☐ Yes	☐ No	☐ Yes	☐ No

Member Name (Please Print) Last | First | Telephone (Residence)

Member Name (Please Print) Last	First	Telephone (Residence)

5. DECLARATION OF INSURABILITY *(continued)*

IF ANY OF QUESTIONS 4 THROUGH 8 ARE ANSWERED "YES", GIVE DETAILS BELOW.

Question Number	Name of person to be insured	Nature of Illness or Injury, or Symptoms	Date Diagnosed & Duration	Result	Name and Address of Physician and Hospital, if any

If you need more space, please complete, sign and date on a separate sheet of paper.

Member (IF ANSWERED "YES" TO QUESTION 9)

	Condition	Age of Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s)*					
Sister(s)*					

*If there are no siblings, indicate "none".

Spouse (IF ANSWERED "YES" TO QUESTION 9)

	Condition	Age of Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s)*					
Sister(s)*					

*If there are no siblings, indicate "none".

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 or territorial health departments, if required by law.

QUESTIONS? Contact Manulife Financial toll-free at **1 888 913-6333,**
Monday to Friday from 8 a.m. to 8 p.m. ET or by e-mail at **am_service@manulife.com**

Send your completed application form along with payment to:

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

TERMS & CONDITIONS – PLEASE READ CAREFULLY

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3

Notice on Exchange of Information

All information requested will be for insurance purposes only and will be treated as confidential. The insurer or its reinsurers may, however, make a brief report on it to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, the bureau will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, the bureau will arrange for disclosure to you of any information it may have in your file on you or your spouse being insured under this plan. If you question the accuracy of the bureau's file, you may contact the bureau and seek a correction. The address of the bureau's information office is: 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

Declaration

I/we, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/we declare that I am/we are resident in Canada and at least 18 but not yet 66 years of age. I/we declare that the statements contained in this application, including the Declaration of Insurability, are true and complete. I/we understand that the application, together with any other forms signed by me/us in connection with this application, forms the basis for any policy issued hereunder. I/we understand that any material misrepresentation, including misstatement of non-smoker status, shall render the insurance voidable at the instance of the insurer. I/we have also read and understand the exclusions and limitations on the coverage applied for. I/we understand that insurance will take effect on the date my/our properly completed application and the first premium are received by Manulife Financial, subject to the approval of the insurer's underwriters, and that I am/we are not eligible for insurance under more than one Alumni Critical Illness Insurance policy issued by Manulife Financial.

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 group 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 or my health, or the health of any member of my family, 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, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me their products or services.

Acknowledgement

I/we agree to the use of my/our personal information for the purposes outlined in this application. I/we understand that my/our consent to the use of any information to offer me/us products and 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 facsimile of this authorization shall be as valid as the original.

Payment Authorization

(For your convenience, if you choose payment by Pre-Authorized Collections Plan or credit card, your future premium billings will automatically reflect the same payment method.)

I/we 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 Manulife Financial or by me/us through written notice. Manulife Financial also reserves the option to change the method of payment for another qualifying mode after the occurrence of a deposit not honoured.

I/we have been made aware of the reasons why the health information is needed and the risks and benefits of consenting or refusing to consent. This is effective on the date signed. This authorization may be revoked at any time by the individual giving it.

❑ Les parties ont expressément convenu que la présente entente ainsi que toute annexe ou document s'y rattachant soient rédigés en anglais. The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

I/we have read and understand the Terms and Conditions and accept them.

Member's Signature *(if Member is applying for coverage)* **Date**

Spouse's Signature *(if Spouse is applying for coverage)* **Date**

Co-signature (for PAC if you have a joint account) **Date**

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