



The Term Life Insurance Plan

For Cardholders

BENEFITS UP TO \$150,000



(A) CARDHOLDER APPLICATION:

PLEASE COMPLETE THE FOLLOWING INFORMATION:

A. Name: _____
FIRST MIDDLE LAST

B. Address: _____

C. City/Prov.: _____

D. Postal code: _____ E. HBC/Bay/Zellers Card Number _____

F. Date of birth (Day/Month/Year): _____

G. Check the coverage amount that you want. You can apply for "Non-Smoker" premiums if you have not used any form of tobacco in the past 12 months. Is the policy applied for intended to replace any existing insurance? No Yes
 If yes, list policy no(s) to be replaced and insurer.

H. Height _____ ft. _____ ins. Weight _____ lbs. Sex: M F

I. Tel (Res): _____ (Bus): _____ E-mail: _____

(B) SPOUSE'S APPLICATION:

Spouse may apply even if Cardholder does not apply. Please complete the cardholder contact information in Section (A), (A-E).

Spouse's full name: _____
FIRST MIDDLE LAST

PLEASE COMPLETE THE FOLLOWING INFORMATION:

A. Spouse's date of birth: _____

B. Check the coverage amount for spouse coverage. You can apply for "Non-Smoker" premiums if you have not used any form of tobacco in the past 12 months. Is the policy applied for intended to replace any existing insurance? No Yes
 If yes, list policy no(s) to be replaced and insurer.

C. Height _____ ft. _____ ins. Weight _____ lbs. Sex: M F

D. Tel (Res): _____ (Bus): _____ E-mail: _____

(C) MAJOR ACCIDENT PROTECTION:

Cardholder (Available only if cardholder is insured under the Term Life Plan)

Major Impairment	Up to \$50,000	Up to \$75,000	Up to \$100,000	Up to \$125,000	Up to \$150,000
Accidental Death	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000
Monthly Premium	\$2	\$3	\$4	\$5	\$6

→ (C) → \$ _____
 Monthly Premium

Spouse (Available only if your spouse is insured under the Term Life Plan)

Major Impairment	Up to \$50,000	Up to \$75,000	Up to \$100,000	Up to \$125,000	Up to \$150,000
Accidental Death	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000
Monthly Premium	\$2	\$3	\$4	\$5	\$6

→ (C) → \$ _____
 Monthly Premium

(D) APPLICATION FOR CHILD TERM LIFE INSURANCE:

Available only if Cardholder is insured under the Term Life Plan.

(One monthly premium of \$2.25 covers all your eligible children for \$10,000 of life coverage each)
 Eligible children are (define them here).

Name	Date of Birth (Day/Month/Year)	Gender
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

\$10,000 Coverage

Please check above if you require child life coverage.

→ \$ 2.25
 Monthly Premium

\$150,000
 Non-Smoker Smoker

\$100,000
 Non-Smoker Smoker

\$50,000
 Non-Smoker Smoker

↓
 \$ _____
 Your Monthly Premium

SEE PREMIUM PAGE ENCLOSED

\$150,000
 Non-Smoker Smoker

\$100,000
 Non-Smoker Smoker

\$50,000
 Non-Smoker Smoker

↓
 \$ _____
 Monthly Premium

SEE PREMIUM PAGE ENCLOSED

E MEDICAL QUESTIONNAIRE:

Please answer the following questions:	Cardholder	Spouse	Children
1. Have you ever had or been told you had heart trouble, tuberculosis, cancer, tumour, diabetes, nervous disorder, ulcer, kidney trouble, urinary disorder, lung or liver disorder, hepatitis (including carrier state), chest pains, abnormal blood pressure, or a health problem relating to the use of alcohol or drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you received medical advice or treatment in connection with AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex), a sexually related disease or tested positive for HIV (Human Immunodeficiency Virus)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Do you have any of the following which are unexplained: fatigue, weight loss, diarrhea, enlarged lymph nodes, unusual skin lesions or any other illness, disease or congenital defect not mentioned above?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you ever been declined, postponed or rated for life or disability insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do you intend to reside outside of Canada? If yes, state country and date: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please provide details to questions answered "yes".					
Ques. #	Name	Nature of disorder	Duration and date	Result	Attending physician or hospital

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

Cardholder's Name (please print)

Spouse's Signature (if applying)

Note: Quebec residents may send this page directly to the insurer.

F BENEFICIARY INFORMATION:

PLEASE COMPLETE THE FOLLOWING INFORMATION:

I/we hereby designate the individual(s) named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for:

Beneficiary for Member's Coverage: _____ Beneficiary for spouse's Coverage: _____

Relationship: _____ Relationship: _____

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

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

TERMS AND CONDITIONS – (Les parties ont expressément convenu que la présente entente ainsi que toute annexes ou documents 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.) Please read carefully before signing.

Declaration

I/we hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/we authorize Manulife Financial to bill my/our monthly premiums to the Cardholder Account for insurance premiums due on or after the date of this authorization. I/we understand that insurance will take effect on the date the 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 Cardholder term life insurance policy issued by Manulife Financial. I/we declare that the statements contained in this application are true and complete. I/we understand that the application together with any other forms signed by me in connection with this application form the basis for any policy 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.)

Authorization

Relative to the insurance applied for, I, 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 or person that has any records or knowledge of me or my health or the health of any member of my family, including any minor children, to be insured under the 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 authorize Manulife Financial to consult its existing files for this purpose. I 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. I understand that my consent to the use of such information to offer me products or services is optional and that if I wish to discontinue such use I may write to Manulife Financial at the address shown on this document. A photocopy or facsimile of this authorization shall be as valid as the original.

I declare that I 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 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 the following page).

Cardholder's Name (please print) Cardholder's Signature (if applying) Date

Spouse's Name (please print) Spouse's Signature (if applying) Date

Completed application should be sent to:
Affinity Markets, Manulife Financial, 5650 Yonge Street, 16th Floor, Toronto, Ontario M2M 4G4
For more information call Manulife Financial at **1 800 665-4051** from 8 am to 8 pm
or e-mail us at **am_service@manulife.com** at any time.

Underwritten by:



The Manufacturers Life Insurance Company

**PREMIUMS ARE
GUARANTEED FOR
5 YEARS**

The Term Life Insurance Plan Monthly Premiums**

\$150,000					\$100,000					\$50,000				
Issue and Renewal Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker	Issue and Renewal Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker	Issue and Renewal Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
18 to 30	17.04	27.30	11.34	18.96	18 to 30	11.36	18.20	7.56	12.64	18 to 30	7.68	11.10	5.78	8.32
31	17.64	28.50	12.18	20.22	31	11.76	19.00	8.12	13.48	31	7.88	11.50	6.06	8.74
32	18.24	29.82	13.08	21.60	32	12.16	19.88	8.72	14.40	32	8.08	11.94	6.36	9.20
33	18.90	31.20	14.04	23.04	33	12.60	20.80	9.36	15.36	33	8.30	12.40	6.68	9.68
34	19.50	32.58	15.06	24.60	34	13.00	21.72	10.04	16.40	34	8.50	12.86	7.02	10.20
35	20.22	34.08	16.14	26.28	35	13.48	22.72	10.76	17.52	35	8.74	13.36	7.38	10.76
36	21.42	37.62	17.46	29.16	36	14.28	25.08	11.64	19.44	36	9.14	14.54	7.82	11.72
37	22.74	41.58	18.90	32.40	37	15.16	27.72	12.60	21.60	37	9.58	15.86	8.30	12.80
38	24.12	45.90	20.46	35.94	38	16.08	30.60	13.64	23.96	38	10.04	17.30	8.82	13.98
39	25.56	50.64	22.14	39.90	39	17.04	33.76	14.76	26.60	39	10.52	18.88	9.38	15.30
40	27.12	55.92	24.00	44.34	40	18.08	37.28	16.00	29.56	40	11.04	20.64	10.00	16.78
41	29.76	61.80	26.28	48.18	41	19.84	41.20	17.52	32.12	41	11.92	22.60	10.76	18.06
42	32.70	68.22	28.74	52.32	42	21.80	45.48	19.16	34.88	42	12.90	24.74	11.58	19.44
43	35.88	75.36	31.50	56.88	43	23.92	50.24	21.00	37.92	43	13.96	27.12	12.50	20.96
44	39.36	83.22	34.50	61.80	44	26.24	55.48	23.00	41.20	44	15.12	29.74	13.50	22.60
45	43.20	91.92	37.74	67.14	45	28.80	61.28	25.16	44.76	45	16.40	32.64	14.58	24.38
46	47.94	101.22	39.60	71.16	46	31.96	67.48	26.40	47.44	46	17.98	35.74	15.20	25.72
47	53.16	111.48	41.52	75.36	47	35.44	74.32	27.68	50.24	47	19.72	39.16	15.84	27.12
48	59.04	122.76	43.56	79.86	48	39.36	81.84	29.04	53.24	48	21.68	42.92	16.52	28.62
49	65.52	135.18	45.72	84.60	49	43.68	90.12	30.48	56.40	49	23.84	47.06	17.24	30.20
50	72.72	148.86	48.00	89.64	50	48.48	99.24	32.00	59.76	50	26.24	51.62	18.00	31.88
51	78.24	159.60	51.06	92.58	51	52.16	106.40	34.04	61.72	51	28.08	55.20	19.02	32.86
52	84.18	171.18	54.30	95.64	52	56.12	114.12	36.20	63.76	52	30.06	59.06	20.10	33.88
53	90.54	183.54	57.78	98.82	53	60.36	122.36	38.52	65.88	53	32.18	63.18	21.26	34.94
54	97.38	196.86	61.44	102.06	54	64.92	131.24	40.96	68.04	54	34.46	67.62	22.48	36.02
55	104.76	211.08	65.40	105.42	55	69.84	140.72	43.60	70.28	55	36.92	72.36	23.80	37.14
56	110.52	226.62	70.26	111.54	56	73.68	151.08	46.84	74.36	56	38.84	77.54	25.42	39.18
57	116.52	243.36	75.48	118.02	57	77.68	162.24	50.32	78.68	57	40.84	83.12	27.16	41.34
58	122.88	261.30	81.06	124.92	58	81.92	174.20	54.04	83.28	58	42.96	89.10	29.02	43.64
59	129.54	280.56	87.06	132.18	59	86.36	187.04	58.04	88.12	59	45.18	95.52	31.02	46.06
60	136.62	301.26	93.54	139.86	60	91.08	200.84	62.36	93.24	60	47.54	102.42	33.18	48.62
61	152.58	339.06	103.26	154.50	61	101.72	226.04	68.84	103.00	61	52.86	115.02	36.42	53.50
62	170.40	381.60	114.00	170.58	62	113.60	254.40	76.00	113.72	62	58.80	129.20	40.00	58.86
63	190.32	429.54	125.88	188.40	63	126.88	286.36	83.92	125.60	63	65.44	145.18	43.96	64.80
64	212.52	483.42	138.96	208.08	64	141.68	322.28	92.64	138.72	64	72.84	163.14	48.32	71.36
65	237.36	544.14	153.42	229.80	65	158.24	362.76	102.28	153.20	65	81.12	183.38	53.14	78.60
* 66	249.96	574.50	160.86	241.02	* 66	166.64	383.00	107.24	160.68	* 66	85.32	193.50	55.62	82.34
* 67	262.56	604.86	168.36	252.24	* 67	175.04	403.24	112.24	168.16	* 67	89.52	203.62	58.12	86.08
* 68	275.16	635.22	175.86	263.46	* 68	183.44	423.48	117.24	175.64	* 68	93.72	213.74	60.62	89.82
* 69	287.70	665.58	183.30	274.74	* 69	191.80	443.72	122.20	183.16	* 69	97.90	223.86	63.10	93.58

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, your spouse or your minor children 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).

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, 5650 Yonge Street, 16th Floor, Toronto, Ontario M2M 4G4.