

1. Member Information

Name of Member (PLEASE PRINT)

Last _____ First _____ Male Female

Address _____ City _____ Province _____ Postal Code _____

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

Member's Date of Birth (DD/MM/YYYY) _____ Country of Birth _____ Non-Smoker Smoker

Applicant is a/an: Engineer Student Technician/Technologist Limited Licensee
 Geoscientist Architect Permanent Full-time Employee of Association Member in Training

Name of Prov./Terr. Assoc. _____ Membership No. _____

2. I am applying for New coverage Additional coverage

Disability Income Replacement (Do not include any coverage currently in force.)

A. Please indicate the monthly benefit amount you are applying for in \$100 increments (maximum \$10,000) \$ _____

B. Choose a Waiting Period* before the benefits begin: 0-7 Days 14 Days 30 Days 90 Days 119 Days 180 Days 365 Days

*If you are covered by Employment Insurance, select a Waiting Period of 90 days or longer.

Business Overhead Expense

A. Please indicate the monthly total reimbursement benefit amount you are applying for in \$100 increments (maximum \$8,000) \$ _____

B. Waiting Period before the benefits begin: 14 Days 30 Days

3. Financial/Employment Information

A. Are you currently employed (includes self-employment)? Yes No

If self-employed,* what is the organizational structure of your business?

Sole Proprietor Partnership Corporation Percentage ownership _____% Start-up date _____ (DD/MM/YYYY)

If self-employed, describe the nature of your business _____

Breakdown of duties: Office _____% Supervisory _____% Manual _____% Driving _____%

B. Net Monthly Earned Income \$ _____

Note: Net monthly earned income means income earned from your employment or profession, after business expenses but before income taxes. Those with fluctuating incomes should use an average figure based on Earned Income over the preceding 24 months.

Are you eligible for Employment Insurance? Yes No

C. 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? _____

D. Do you have any pending life or existing disability or business overhead expense insurance coverage in force with Manulife or any other company? Yes No If yes, complete the following:

Company Name	Coverage Amount	Waiting Period	Benefit Period	Taxable?	Will this coverage be replaced?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new certificate.

E. 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.

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

G. For Business Overhead Expense applicants: Your share of Average Monthly Overhead Expenses (not including salary paid to yourself): \$ _____

*Benefits for newly self-employed members may be limited.

4. Method of Payment

<input type="checkbox"/> Annual† <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <div style="text-align: center;"> <input style="width: 150px;" type="text"/> <small>Total Monthly Premium</small> </div> <div style="text-align: center;"> $\div .09 +$ </div> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>Provincial Sales Tax if applicable</small> </div> <div style="text-align: center;"> $= \\$ </div> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>AMOUNT PAYABLE</small> </div> </div> <p style="margin-top: 10px;">a) <input type="checkbox"/> My cheque is enclosed, made payable to "Manulife Financial"</p> <p style="margin-top: 5px;">OR</p> <p>b) <input type="checkbox"/> Charge my: <input type="checkbox"/> <input type="checkbox"/> </p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>Card No.</small> </div> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>Expiry Date</small> </div> </div>	<input type="checkbox"/> Monthly <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <div style="text-align: center;"> <input style="width: 150px;" type="text"/> <small>Total Monthly Premium</small> </div> <div style="text-align: center;"> $+$ </div> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>Provincial Sales Tax if applicable</small> </div> <div style="text-align: center;"> $= \\$ </div> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>MONTHLY AMOUNT PAYABLE</small> </div> </div> <p style="margin-top: 10px;">a) <input type="checkbox"/> By Pre-Authorized Collection Plan (PAC). Enclose a sample cheque marked "VOID"</p> <p style="margin-top: 5px;">OR</p> <p>b) <input type="checkbox"/> Charge my: <input type="checkbox"/> <input type="checkbox"/> </p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>Card No.</small> </div> <div style="text-align: center;"> <input style="width: 100px;" type="text"/> <small>Expiry Date</small> </div> </div>
<p>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 Collection Plan may be terminated either by 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.</p> <p>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.</p> <p>† Residents of Ontario add 8% Provincial Sales Tax. Residents of Québec add 9% Provincial Sales Tax.</p>	

5. Health Declaration

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	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	Member's Weight	<input type="checkbox"/> lbs <input type="checkbox"/> kg	Has your weight changed in the past year?	<input type="checkbox"/> Gained <input type="checkbox"/> Lost	<input type="checkbox"/> lbs <input type="checkbox"/> kg	
				<input type="checkbox"/> Yes <input type="checkbox"/> No			

	Member YES NO	
1. Have you ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you within the past 5 years, had your driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details, including nature of offence(s), date(s), driver's licence no. and licensing province: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 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 type of activity and date(s): <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the next 12 months, have you any intention of travelling or residing outside North America? If yes, give details, including where, when, why and for how long: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you 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 drug or alcohol type(s) and date(s) last used: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Female applicants only: a) Are you currently pregnant? If yes, give due date: <input style="width: 100%; height: 20px;" type="text"/> b) Have you ever had a miscarriage, pre-eclampsia, caesarean section or other complication of pregnancy? If yes, give date and details: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you 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?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you 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?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had any positive test, treatment for or exposure to HIV virus or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>

5. Health Declaration (continued)

10. Have you 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, flus, etc.), been advised to undergo further investigation, see another doctor or have surgery?

If you answered yes to any of Questions 7 through 10, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question No.	Nature of Disorder	Date and Duration	Treatment & Current Status	Attending Physician or Hospital

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:

Family Member	Condition (If cancer, specify type)	Age at Onset	Age at Death and Cause

Member	
YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

6. Terms and Conditions *(Please read carefully before signing)*

I (the member) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial).

I declare that the statements contained in this application, including the Health Declaration originally attached hereto, are true and complete. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any certificate issued hereunder.

The person to be insured understands that any material misrepresentation shall render the insurance voidable at the instance of the insurer. I understand that exclusions and limitations apply to the coverage applied for. Relative to the insurance applied for, I, the person 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 or my health or the health of any member of my 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 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 faxed copy of this authorization shall be as valid as the original.

I acknowledge receipt of, and confirm my agreement with, the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.

Insurance will take effect on the first of the month following approval of the completed application by Manulife, as long as the initial premium is paid.

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. Suicide within two years of the effective date is a risk not covered under the Term Life plan.

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.

Insurance will take effect on the date the properly completed application (including my properly completed 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.

If 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 premiums will be made.

Member's Signature

Date (DD/MM/YYYY)

Signed at

Co-Signature (for Pre-Authorized Collection, if required by bank)

Date (DD/MM/YYYY)

Signed at

Representative's Name (if applicable)

Code No.

Questions? Call toll-free 1 877 598-2273 or e-mail us at am_service@manulife.com