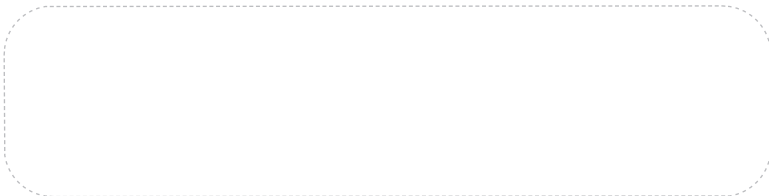


ASSOCIATION GROUP INSURANCE

COMPLETING AND RETURNING THIS APPLICATION FORM COULD BE THE BEST THING YOU'VE EVER DONE TO HELP SECURE YOUR FINANCIAL FUTURE AND THE FUTURE OF YOUR FAMILY. FOR THE AFFORDABLE PROTECTION THAT YOUR PROFESSIONAL ASSOCIATION GROUP PLAN CAN PROVIDE, PLEASE REPLY TODAY!



Members and Spouses must be between 18 and less than 61 years of age. Eligible children are those unmarried, dependent on the member for support and over 14 days of age and under 21 or over 20 but less than 25 years of age if attending school or university full time. All applicants must be residing in Canada.

WHEN APPLYING FOR COVERAGE, PLEASE COMPLETE ALL INFORMATION REQUESTED BELOW.

MEMBER INFORMATION

Name First Last Male Female

Unit/Apt. # No./Street City

Province Postal Code Tel. Res. () Bus. ()

E-mail† Date of Birth Day / Month / Year Country of Birth

Applicant is a member of:

OR (specify in what capacity, in relation to the above Association/Society you are applying) Name of Association/Society

†Your e-mail address is important to us. At Manulife Financial we value your privacy. We do not sell or rent out our customer information. From time to time you may receive e-mails from us about new products and relevant information. Each time you receive an e-mail from us, you will have the option to opt out of our mailing list.

SPOUSE INFORMATION (if applying for spouse coverage)

Name First Last Male Female

Date of Birth Day / Month / Year Country of Birth Occupation

BENEFITS APPLIED FOR AT THIS TIME (Do not include units already in force)

New Coverage Additional Coverage Certificate # (if currently insured) **MONTHLY PREMIUM**

Member Term Life Insurance Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/>	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$	<input type="text"/>
Minimum – 2 Units					
10% rate reduction for volume purchase (if coverage is 8 or more units) →	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	X .9	= \$ <input type="text"/>
Spouse Term Life Insurance Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/>	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$	<input type="text"/>
Available only if you participate in the Member Term Life Plan. Minimum – 2 Units					
10% rate reduction for volume purchase (if coverage is 8 or more units) →	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	X .9	= \$ <input type="text"/>
Child Term Life Insurance	No. of Children <input type="text"/>		Premium \$2.25	= \$	<input type="text"/>
Available only if you participate in the Member Term Life Plan. (One monthly premium covers all your eligible children for \$10,000 of life coverage each.)					
Member Income Protection Insurance	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$	<input type="text"/>
Waiting period <input type="text"/> days.					
Office Overhead Expense Insurance	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$	<input type="text"/>
Waiting period <input type="text"/> days.					
Member Personal Accident Insurance	No. of Units <input type="text"/>	X	Premium Per Unit \$1.50	= \$	<input type="text"/>
Available only if you participate in the Member Term Life Plan.					
Spouse Personal Accident Insurance	No. of Units <input type="text"/>	X	Premium Per Unit \$1.50	= \$	<input type="text"/>
Available only if you participate in the Spouse Term Life Plan.					
<small>*Non-Smoker rates apply to people who have not smoked cigarettes in the past 12 months and who meet Manulife Financial's health standards.</small>					
TOTAL MONTHLY PREMIUM					= \$ <input type="text"/>

All Applicants: This application is not valid unless the Underwriting Questionnaire section is properly completed and the application is signed.

Québec Residents: After completion, you may detach this section and send it directly to the insurance company in the enclosed business reply envelope.

UNDERWRITING QUESTIONNAIRE - PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS

Member's Physician Name Tel. # Date last seen (D/M/Y)

Reason for Visit Result

Spouse's Physician Name Tel. # Date last seen (D/M/Y)

Reason for Visit Result

Member's Height Weight Spouse's Height Weight

Has any individual proposed for coverage:

1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including carrier state), kidney disorder, urinary abnormality, unusual infection or immune system abnormality, or other illness not mentioned?.....	Member YES <input type="checkbox"/> NO <input type="checkbox"/>	Spouse YES <input type="checkbox"/> NO <input type="checkbox"/>	Child(ren) YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Ever been treated for or advised to reduce alcohol or drug use?.....	Member YES <input type="checkbox"/> NO <input type="checkbox"/>	Spouse YES <input type="checkbox"/> NO <input type="checkbox"/>	Child(ren) YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Ever had back, neck, hip or knee trouble, been treated for chronic pain or fibromyalgia, had X-rays of spine or joints or been hospitalized or disabled by any injuries?.....	Member YES <input type="checkbox"/> NO <input type="checkbox"/>	Spouse YES <input type="checkbox"/> NO <input type="checkbox"/>	Child(ren) YES <input type="checkbox"/> NO <input type="checkbox"/>

