

Alumni Critical Illness Insurance APPLICATION FORM



The Manufacturers Life Insurance Company

Before applying for Critical Illness Insurance, it is important to understand that this plan is **not available to you if you or your spouse (if applying) have had 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
- Transient Ischemic Attack

Alum.CI.E (02/10)

Member Information *(Please print)*

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

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

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

Other Insurance Information

Does any applicant have any pending or existing critical illness insurance coverage with Manulife Financial or any other company?

Yes No If yes, please complete the following:

Name of Applicant	Company Name	Amount	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 new contract.

How much insurance are you applying for?

I am applying for New coverage Additional coverage If currently insured under these plans, list Policy No. _____

If applying for additional coverage, DO NOT INCLUDE COVERAGE ALREADY IN FORCE.

MEMBER CRITICAL ILLNESS INSURANCE

Smoker Non-Smoker*

SPOUSE CRITICAL ILLNESS INSURANCE

Smoker Non-Smoker*



<p>Amount of coverage applied for</p> <p>\$ _____</p> <p>Available from \$25,000 to \$250,000 in increments of \$25,000</p>

<p>Amount of coverage applied for</p> <p>\$ _____</p> <p>Available from \$25,000 to \$250,000 in increments of \$25,000</p>

*Non-Smoker rates apply to people who have not used tobacco, tobacco cessation products or marijuana in the last 12 months and who meet Manulife Financial's health standards.

Advisor's Report (For agent use only)

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your Name (First, Middle Initial, Last)

Advisor code

Signature

Québec residents only: After completion of the Underwriting Questionnaire you **may** send it directly to Manulife Financial at the address shown on page 6.

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

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

Member's Full Name		Home Telephone		Spouse's Full Name			
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 last seen				Reason last seen			
Tests, Treatment, Medication prescribed (if none, state "None")				Tests, Treatment, Medication prescribed (if none, state "None")			
Results and current status				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		Spouse's Height <input type="checkbox"/> ft/in <input type="checkbox"/> cm		Spouse's Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg	
Has your weight changed in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Gained <input type="checkbox"/> Lost		<input type="checkbox"/> lbs <input type="checkbox"/> kg		Has your weight changed in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Gained <input type="checkbox"/> Lost		<input type="checkbox"/> lbs <input type="checkbox"/> kg	

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

	MEMBER		SPOUSE	
	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"/>
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"/>
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 name of applicant, type of activity and date(s): _____ _____	<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"/>
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"/>
6. 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, thyroid nodule, skin disorder, gastrointestinal disorder, disorder of the eyes, visual disturbance, optic neuritis or other illness not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Underwriting Questionnaire (Continued)

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

MEMBER		SPOUSE	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc.), arthritis, paralysis, weakness of the extremities, numbness, tingling, loss of balance, loss of sensation, fibromyalgia or chronic pain, had X-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks?
8. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?
9. 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, flu, etc.), been advised to undergo further investigation, see another doctor, have surgery, have tests completed (including CT scan or MRI) or are you awaiting any test results?

If you answered "yes" to any of Questions 6, 7, 8 or 9 above, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question #	Name of Applicant	Nature of Disorder	Date and Duration	Treatment and Current Status	Attending Physician or Hospital

10. 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:

MEMBER		SPOUSE	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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 Member. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law. 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.

Financial Information

Member Annual Net Earned Income, after expenses but before taxes \$ _____ Personal Net Worth (assets less liabilities) \$ _____	Spouse Annual Net Earned Income, after expenses but before taxes \$ _____ Personal Net Worth (assets less liabilities) \$ _____
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Terms & Conditions *(Please read carefully before signing)*

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 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 that there are 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 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/us or my/our health, 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/us their products or services.

I acknowledge receipt of and confirm my agreement with the Notice on Exchange of Information and the Notice on Privacy and Confidentiality. 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 of 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.

FOR QUÉBEC RESIDENTS: 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**

QUESTIONS?

CALL MANULIFE FINANCIAL, TOLL-FREE: **1-888-913-6333** or e-mail: **am_service@manulife.com**

PLEASE SEND YOUR COMPLETED APPLICATION IN THE POSTAGE-PAID ENVELOPE, ALONG WITH PAYMENT, TO:
Manulife Financial, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8