



EXTENDED HEALTH CARE & DENTAL INSURANCE

MEMBER INFORMATION

Form fields for Member Information including Name of Member, Unit/Apt. #, Province, Postal Code, Tel: Res, Bus, E-mail, Member's Date of Birth, Birthplace, and Date Real Estate Licence obtained.

SPOUSE INFORMATION (if applying for spousal coverage)

Form fields for Spouse Information including Name of Spouse, Spouse's Date of Birth, Birthplace, and Spouse's Occupation.

BENEFITS APPLIED FOR AT THIS TIME

MONTHLY PREMIUM

Form for selecting benefits: Member Extended Health Care (EHC) Benefits, Spouse Extended Health Care Benefits, and Child Extended Health Care Benefits. Includes fields for No. of Children and Premium Per Child.

TOTAL MONTHLY PREMIUM => = \$ []

PAYMENT MODE

Form for selecting payment mode: Annual, My cheque is enclosed, Charge to my (VISA/MasterCard), or Monthly (by Pre-Authorized Collections). Includes calculation of AMOUNT PAYABLE and MONTHLY AMOUNT PAYABLE.

Please Note: If you choose payment by PAC or Credit Card, for your convenience your future premium billings will automatically reflect this same payment method. 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.

†Residents of Ontario add 8% Provincial Sales Tax. Residents of Québec add 9% Provincial Sales Tax.

HEALTH DECLARATION

Member's Physician _____
Name Telephone Number Date last seen (D/M/Y)

Reason for last visit _____ Result of last visit _____

Spouse's Physician _____
Name Telephone Number Date last seen (D/M/Y)

Reason for last visit _____ Result of last visit _____

Member's Height _____ Weight _____ Spouse's Height _____ Weight _____

	Member		Spouse		Children	
	YES	NO	YES	NO	YES	NO
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), unusual infection or immune system abnormality, kidney disorder, urinary abnormality, or other illness not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever had back, neck or knee trouble, been treated for chronic pain or fibromyalgia, had any x-rays of spine or joints, or received any injuries for which he/she was hospitalized or was unable to work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had any positive tests or exposure to HIV/AIDS virus or, during the past two years, had any medical or surgical advice, been hospitalized, treated or given medication for any ailment other than routine check-ups or minor ailments (colds, flus, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever applied for any insurance that was declined, modified or rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Engaged in or intend to engage in, any hazardous sport or activity, eg. flying (except as a fare-paying passenger on a commercially licensed carrier), racing, scuba or sky diving, climbing, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had his or her driver's licence suspended or been charged with impaired driving? If yes, provide driver's licence # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Smoked cigarettes in the last 12 months? (If other forms of tobacco used, give details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" answered to any of questions 1 to 4 above, give details below. For 5 and 7, use separate page.

QUES. #	NAME	NATURE OF DISORDER	DURATION AND DATE	RESULT	ATTENDING PHYSICIAN OR HOSPITAL

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. Positive results of any tests for infectious diseases will be reported to health authorities as required by law.

List all medications or other treatment (therapy, counselling, etc.) that any individual to be insured is currently taking or expects to be taking, or that has been prescribed within the past 12 months, including unfilled prescriptions. **If none, state "None"**.

NAME	MEDICATION OR TREATMENT	DATE PRESCRIBED DD/MM/YY	DOSAGE AND FREQUENCY	MONTHLY COST	DATE DISCONTINUED (IF APPLICABLE)	REASON FOR USE

TERMS AND CONDITIONS – Please read carefully before signing.

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: Information Access 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, your spouse or your 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).

Acknowledgement. I understand and acknowledge receipt of the Notice on Privacy and Confidentiality and the Notice on Exchange of Information as detailed in this application and agree to the use of my personal information for the purposes outlined in those notices and in this application.

I understand that my consent to the use of any information beyond that required to administer the insurance applied for 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.

Declaration. I (the member) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/we declare that the statements contained in this application are true and complete and together with any other forms signed by me/us in connection with this application form the basis for any certificate 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. 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 Company's underwriters.

Authorization. Relative to the insurance applied for, I/we, the undersigned applicant(s), or parent/guardian if the applicant 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, institution or person that has any records or knowledge of me/us or my/our health or the health of any member of my/our family to be insured under these plans to give 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/we understand that my/our consent to the use of such information to offer me/us products or services is optional and that if I/we wish to discontinue such use I/we 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.

Le(s) propositant(s) accepte(nt) que ce document soit en anglais.

Member's Signature _____ Date _____

Spouse's Signature _____ Date _____
(if member applying for spousal coverage)

Co-Signature _____ Date _____
(for Pre-Authorized Collections, if required by bank)

Representative's Name (if applicable) _____ Code # _____

Completed applications should be sent to:
Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3

QUESTIONS? PLEASE E-MAIL MANULIFE FINANCIAL AT: am_service@manulife.com

OR TELEPHONE TOLL-FREE: 1 800 668-0195 (in Toronto)

Monday through Friday, 8:30 a.m. to 8:00 p.m. ET.