



The Canadian
Real Estate
Association

APPLICATION FOR
REALTORS®



INCOME PROTECTION DISABILITY 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 only your CREA group plan can provide, please reply today!

Member Information

Name of Member _____ Male Female
Last First

Unit/Apt. # _____ No./Street _____ City _____

Province _____ Postal Code _____ Tel: Res: (____) _____ Bus: (____) _____

E-mail: Res: _____ Bus: _____

Member's Date of Birth _____ Birthplace _____
Day Month Year

Date Real Estate Licence obtained: _____
Day Month Year

(For Income Protection coverage, the minimum licencing period for Plan A is two years and for Plan B is one year.)

Benefits applied for at this time

MONTHLY PREMIUM

Member Income Protection Insurance Plan A Plan B
Available only if you participate in the Member Term Life plan.

No. of Units x Premium Per Unit = \$

Waiting period days.

Optional - Cost of Living Adjustment
If selected, must be added to all Income Protection units.

No. of Units x Premium Per Unit = \$

TOTAL MONTHLY PREMIUM ⇔ = \$

Payment Mode

Annual \$ _____ x _____ + _____ † = \$ _____
Total Monthly Premium No. of Months to July 1st (excluding present month) Provincial Sales Tax (if applicable) AMOUNT PAYABLE

My cheque is enclosed, made payable to Manulife Financial OR

Charge to my: Card No. _____ Expiry Date _____

Monthly (by Pre-Authorized Collections) Enclose a sample cheque marked "VOID".

\$ _____ + **\$2.00** + _____ † = \$ _____
Total Monthly Premium Service Charge Provincial Sales Tax (if applicable) 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. The Pre-Authorized Collections Plan may be terminated by either 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 deposit not honoured.

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

Underwriting Questionnaire

Your Physician _____

Name

Telephone Number

Date last seen (D/M/Y)

Reason for last visit _____

Result of last visit _____

Member's Height _____

Weight _____

Have you:

YES	NO
-----	----

1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumours, lung or liver disorders, hepatitis (including carrier state), unusual infection or immune system abnormality, kidney disorders, urinary abnormality, drug or alcohol consumption, or other illness or injury?
2. Ever had back, neck or knee trouble, had any x-rays of spine or joints, or received any injuries for which you were hospitalized or was unable to work?
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.)?
4. Ever applied for any insurance that was declined, modified or rated?
5. Engaged in or intend to engage in, any hazardous sport or activity (flying, racing, scuba or sky diving, climbing, etc.)?
6. Ever had your driver's licence suspended? If yes, driver's licence # _____
7. Smoked cigarettes in the last 12 months? (If other forms of tobacco used, give details.)

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

QUES. #	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.

List all medications or other treatment (therapy, counselling, etc.) that the 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".

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

Income Information

1. Monthly Earned Income \$ _____ (PLEASE ENCLOSE COPIES OF YOUR T-1 TAX RETURN FOR THE PRECEDING 2 YEARS)

Note: Earned Income means income earned from your employment or profession, after business expenses but before income taxes. Those with fluctuating incomes may use an average figure based on Earned Income over the preceding 2 years.

2. Will any income be continued during disability by an employer or as a result of a partnership agreement? Yes No

If "yes", what percentage? _____% For how many months? _____

3. Is there any other Income Protection Insurance in force or applied for? Yes No If "yes", give details:

Amount (monthly) \$ _____ Benefit period (years) _____

If any of the above coverage will be terminated, give details: _____

To be read and signed by the member

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

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.

TERMS AND CONDITIONS – Please read carefully before signing.

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 _____

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, New Business, Manulife Financial, 5650 Yonge Street, 16th Floor, Toronto, Ontario M2M 4G4

QUESTIONS? Please E-mail Manulife Financial at: **am_service@manulife.com**

Or Telephone Toll-free: **1 800 668-0195 (416 229-3000 in Toronto)**

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