



IMPORTANT NOTICE

Before applying for Critical Illness Insurance, it is important to understand that this plan is not available to you if you have had any of the following conditions or procedures:

- | | |
|--|--|
| Active hepatitis | Huntington's chorea |
| AIDS or AIDS-related disease | Kidney disease - other than kidney stones or a history of kidney infection |
| Alcohol abuse in the past five years | Lou Gehrig's disease - amyotrophic lateral sclerosis (ALS) |
| Alzheimer's disease | Major organ transplant recipient |
| Any heart condition or heart trouble (excluding controlled hypertension) | Multiple sclerosis |
| Cancer - all cancer except basal cell skin cancer | Permanent paralysis (paraplegia, quadriplegia) - other than Bell's palsy |
| Coronary bypass surgery | Pulmonary fibrosis |
| Diabetes | Stroke - cerebrovascular accident |
| Heart attack | |

1. MEMBER INFORMATION

Male Female

Name (Please Print) Last _____ First _____

Address _____ Unit/Apt.# _____ City _____ Province _____ Postal Code _____

Telephone (Residence) () - () Telephone (Business) () - () E-mail Address _____

Date of Birth (DD/MM/YYYY) _____ Place of Birth _____ Occupation _____ CAA Membership Number _____

2. SPOUSE INFORMATION (if applying for coverage)

Male Female

Name (Please Print) Last _____ First _____ Relationship _____

Address _____ Unit/Apt.# _____ City _____ Province _____ Postal Code _____

Telephone (Residence) () - () Telephone (Business) () - () E-mail Address _____

Date of Birth (DD/MM/YYYY) _____ Place of Birth _____ Occupation _____ CAA Membership Number _____

3. HOW MUCH INSURANCE ARE YOU APPLYING FOR?

Member Smoker Non-Smoker*

a) Do you have any Critical Illness insurance in force or pending with another company? Yes No
If yes, total amount _____ Date issued or applied for _____

b) Indicate the amount of coverage you require in \$25,000 increments.
 \$25,000 of coverage \$50,000 of coverage \$75,000 of coverage \$ _____,000
 \$100,000 of coverage Other (please specify) _____
 Coverage Amount

c) Premium Refund Option - Please check if you require the premium refund option. Yes No



Spouse Smoker Non-Smoker*

a) Do you have any Critical Illness insurance in force or pending with another company? Yes No
If yes, total amount _____ Date issued or applied for _____

b) Indicate the amount of coverage you require in \$25,000 increments.
 \$25,000 of coverage \$50,000 of coverage \$75,000 of coverage \$ _____,000
 \$100,000 of coverage Other (please specify) _____
 Coverage Amount

c) Premium Refund Option - Please check if you require the premium refund option. Yes No

* Non-Smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife Financial's health standards.

4. PAYMENT METHOD Please check only one.

Option #1
 CREDIT CARD: Monthly or Annually
 Credit Card No. [] [] [] [] - [] [] [] [] - [] [] [] [] Expiry Date [] [] [] []

OR

Option #2
 MONTHLY
 (BY PRE-AUTHORIZED COLLECTIONS) - PAC.
 Enclose a sample cheque marked "VOID".

OR

Option #3
 ANNUALLY
 (BY CHEQUE, payable to Manulife Financial).

5. DECLARATION OF INSURABILITY

1. Member

Height _____ m _____ cm Weight _____ kg
 _____ ft _____ in _____ lb

Any weight changes Yes No Indicate amount _____ kg
 in the past 12 months? of change, if any _____ lb

Loss Gain Reason: _____

2. Member

A. Name and Address of your Regular Attending Physician:

B. Date and reason last consulted: Date: _____

Reason: _____

C. Diagnosis, treatment given or medication prescribed:

Spouse

Height _____ m _____ cm Weight _____ kg
 _____ ft _____ in _____ lb

Any weight changes Yes No Indicate amount _____ kg
 in the past 12 months? of change, if any _____ lb

Loss Gain Reason: _____

Spouse

Name and Address of your Regular Attending Physician:

Date and reason last consulted: Date: _____

Reason: _____

Diagnosis, treatment given or medication prescribed:

3.

A. Have you ever had any insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?

Yes No

Yes No

If you answered "Yes" please provide details below.

Name	Details (If you need more space, please complete on a separate sheet of paper, sign and date it.)

4.

Have you ever:

A. Consulted any physician, psychiatrist or other health care professional or been admitted to any hospital or similar institution other than for routine physicals or minor conditions (such as cold, flus, etc.)?

Yes No

Yes No

B. Had any symptoms or adverse findings or were you advised to have further examinations, diagnostic tests, hospitalization or surgery not yet done?

Yes No

Yes No

C. a) Have you ever had an abnormal EKG?

Yes No

Yes No

b) In the past 5 years have you had any abnormal examination, x ray, blood test or other diagnostic test?

Yes No

Yes No

D. In the past 5 years have you had any surgical operation, treatment, special diet, illness or injury?

Yes No

Yes No

5.

A. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?

Yes No

Yes No

B. Are you receiving any treatment or taking any medication at the present time?

Yes No

Yes No

6.

Have you ever had or been treated for any disease or disorder of:

A. The heart or blood vessels, such as heart murmur, heart palpitations, heart disease, heart attack, angina, chest pain, circulatory problems, phlebitis, stroke, transient ischemic attack (TIA), high blood pressure, high cholesterol, abnormal ECG, or any other disorder of the heart or circulatory system?

Yes No

Yes No

B. The chest, lungs, nose, or throat, such as asthma, chronic bronchitis, emphysema, loss of speech, or any other chronic lung or respiratory disorder

Yes No

Yes No

C. The digestive system, including stomach, intestines, liver or pancreas, such as ulcer, colitis, bleeding or hepatitis, including carrier state

Yes No

Yes No

D. The kidneys, bladder, reproductive organs or prostate?

Yes No

Yes No

E. The nervous system, such as dizziness, headaches, seizure, paralysis, epilepsy, Parkinson's, Alzheimer's, motor neuron disease (ALS or Lou Gehrig's disease); or any other disease or disorder?

Yes No

Yes No

	Member	Spouse
F. The glandular system or blood, such as diabetes, anemia, leukemia or other disease or disorder of the blood or glandular system?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
G. The immune system, persistent lymph gland enlargement, unusual infections, any other immune system abnormality or had a positive test related to HIV or been diagnosed with AIDS?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
H. The breast, including lumps, cysts, unusual discharge, other physical changes, abnormal mammogram finding or biopsy?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
I. Cancer, tumour, polyp, mole, lump or other growth, any disorder of the skin or lymph glands, blood disorder or other form of malignant disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
7. Have you ever had or been treated for an illness, disease, operation, injury or congenital defect not listed above or do you have any symptoms or complaints for which you have not yet consulted a physician?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
8. A. Within the last two years, have you had your driver's licence suspended or had two or more moving violations?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
B. Have you used marijuana or taken drugs for other than medical purposes or been advised to reduce alcohol consumption or received treatment for drug or alcohol use?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
C. Have you used cigarettes in the past 12 months?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
If other forms of tobacco used, please give details Member: _____ Spouse: _____		
9. Have any of you immediate family members (father, mother, brother(s) and sister(s) had heart disease, stroke, hypertension, aneurysm, cancer (specify type), diabetes, kidney disease or any other hereditary disorder? If yes, please provide details.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

IF ANY OF QUESTIONS 4 THROUGH 8 ARE ANSWERED "YES", GIVE DETAILS BELOW. 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.

Question Number & Part (eg. 6.; A.)	Name of person to be insured	Include (when applicable) all information as to Nature of Illness or Injury, or Symptoms	Date Diagnosed	Name and Address of Physician and Hospital, if any

If you need more space, please complete, sign and date on a separate sheet of paper.

Member

	Condition	Age of Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s)*					
Sister(s)*					

*If there are no siblings, indicate "none".

Spouse

	Condition	Age of Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s)*					
Sister(s)*					

*If there are no siblings, indicate "none".

If you need assistance, call Manulife Financial toll-free at: **1 877-942-4222**, Monday through Friday, from 8:00 a.m. to 8:00 p.m. Eastern Time, or e-mail am_caa@manulife.com

6. 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, 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).

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 form 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 understood the “Limitations and Exclusions” and “Important Notice” section of the enclosed brochure. 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 not eligible for insurance under more than one CAA Critical Illness Insurance Plan policy issued by Manulife Financial.

Authorization.

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 or my 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 their products or services.

Acknowledgement.

I/we acknowledge receipt of the Notice on Privacy and Confidentiality and the Notice on Exchange of Information and I/we agree to the use of my/our personal information for the purposes outlined in this application. I/we understand that my/our consent to the use of any information beyond that required to administer the insurance applied for 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.

Payment Authorization.

For your convenience, if you choose payment by Pre-Authorized Collections Plan or credit card, your future premium billings will automatically reflect the 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 Manulife Financial or by me through written notice. Manulife Financial also reserves the option to change the method of payment for another qualifying mode after the occurrence of a deposit not honoured.

Les parties ont expressément convenu que la présente entente ainsi que toute annexe ou document s’y rattachant soient rédigés en anglais.

Member’s Signature
(if Member is applying for coverage)

Date

Spouse’s Signature
(if Spouse is applying for coverage)

Date

Co-signature for PAC if required by bank

Date

**Completed applications should be sent to: Affinity Markets, Manulife Financial,
5650 Yonge Street, 16th Floor, Toronto, Ontario M2M 4G4**

Insurance underwritten by The Manufacturers Life Insurance Company (Manulife Financial)