

APPLICATION FOR ASSOCIATION GROUP INSURANCE

Member Information *(Please print.)*

ELIGIBILITY: The Applicant must belong to one of the following categories to apply for, or to keep, insurance under the plan.

I am a:

- | | | |
|--|--|--|
| <input type="checkbox"/> Member of OAA | <input type="checkbox"/> Member of AIBC | <input type="checkbox"/> Architectural Partner of OAA or AIBC Member |
| <input type="checkbox"/> Member of B.C. Society of Landscape Architects | <input type="checkbox"/> Member of Canadian Society of Landscape Architects | <input type="checkbox"/> Full-time Employee of OAA, AIBC, BCCLA, CSLA or Pro-Demnity Insurance Company |
| <input type="checkbox"/> Member of Ontario Association of Landscape Architects | <input type="checkbox"/> Member of the Board of Directors or the Executive Committee of the CSLA | <input type="checkbox"/> Full-time office employee of an OAA, AIBC, BCCLA or CSLA member |

Last Name	First Name and Initial(s)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address	City	Province	Postal Code
Date of Birth	Country of Birth		
E-mail	Tel. (Residence)		(Bus.)
Occupation	Self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe nature of business and duties.</i>		

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

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

Child Information *(Complete only if applying for Child coverage.)*

Name of Child	Gender	Date of Birth	Height	Weight	Name and Address of Family Doctor
	<input type="checkbox"/> M <input type="checkbox"/> F	DD/MM/YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kg	
	<input type="checkbox"/> M <input type="checkbox"/> F	DD/MM/YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kg	
	<input type="checkbox"/> M <input type="checkbox"/> F	DD/MM/YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kg	

If more space is needed, complete a separate sheet, signed and dated.

Other Insurance Information

Do you (Member or Spouse) have any existing insurance coverage with Manulife Financial or any other company? Yes No If yes, please complete the following:

Name of Applicant	Company Name	Type of Insurance (life, disability, office overhead expense)	Amount	Waiting Period (for disability)	Benefit Period (for disability)	Non-taxable or Taxable? (for disability)	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
			\$				<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 OAA contract.

Insurance Plan Choices

I am applying for New coverage Additional coverage. If currently insured under these plans, list Certificate No. _____
 If applying for additional coverage, DO NOT INCLUDE COVERAGE ALREADY IN FORCE.

MEMBER: Smoker Non-Smoker¹ SPOUSE: Smoker Non-Smoker¹

¹ Non-Smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife Financial's health standards.

Term Life Insurance (maximum of 16 units is available)

MEMBER \longrightarrow x = \$
 No. of Units Premium Per Unit

Volume Purchase Rates (When Member coverage reaches 6 units or more) x x .9 = \$
 No. of Units Premium Per Unit

SPOUSE \longrightarrow x = \$
 No. of Units Premium Per Unit

Volume Purchase Rates (When Spouse coverage reaches 6 units or more) x x .9 = \$
 No. of Units Premium Per Unit

Member Income Protection Insurance (maximum of 45 units is available)

Waiting Period Days x = \$
 No. of Units Premium Per Unit

Member Office Overhead Expense Insurance** (maximum of 35 units is available)

Waiting Period Days Benefit Period Months x = \$
 No. of Units Premium Per Unit

** Applicant must be an active self-employed member of OAA, OALA, AIBC, BCSLA or CSLA.

Personal Accident Insurance (maximum of 8 units available)

MEMBER Available only if you participate in the Member Term Life Plan. x = \$
 No. of Units Premium Per Unit

SPOUSE Available only if you participate in the Member Term Life Plan. x = \$
 No. of Units Premium Per Unit

Child Term Life Insurance

Available only if you participate in the Member Term Life Plan.

No. of children: (One monthly premium covers all your eligible children for \$5,000 of life coverage each.) = \$

TOTAL MONTHLY PREMIUM = \$

Beneficiary Designation

Beneficiary of Member Coverage

Last Name	First Name
Relationship	

In Québec, a beneficiary designation in favour of a spouse is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

The Member is automatically the beneficiary of any Child coverage applied for.
 If the beneficiary is under the age of 18, please name a Trustee to receive the monies in trust for the beneficiary.

Name of Trustee for any Minor Beneficiary

Beneficiary of Spouse Coverage

Last Name	First Name
Relationship	

In Québec, a beneficiary designation in favour of a spouse is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

The Member is automatically the beneficiary of any Spouse coverage, unless otherwise indicated by the Member in writing.
 If the beneficiary is under the age of 18, please name a Trustee to receive the monies in trust for the beneficiary.

Name of Trustee for any Minor Beneficiary

Underwriting Questionnaire

This application is not valid unless all questions are fully completed.

Member's Full Name		Home Telephone	
Member's E-mail Address			
Member's Physician (Name)		Telephone	
Physician's Address			
Date Last Seen (dd/mm/yyyy)			
Reason Last Seen			
Tests, Treatment, Medication Prescribed (If None, state "None")			
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
Has your weight changed in the past year?		<input type="checkbox"/> Gained	<input type="checkbox"/> lbs
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Lost	<input type="checkbox"/> kg

Spouse's Full Name		Home Telephone	
Spouse's E-mail Address			
Spouse's Physician (Name)		Telephone	
Physician's Address			
Date Last Seen (dd/mm/yyyy)			
Reason Last Seen			
Tests, Treatment, Medication Prescribed (If None, state "None")			
Results and Current Status			
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"/> Gained	<input type="checkbox"/> lbs
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Lost	<input type="checkbox"/> kg

IMPORTANT: Please read.

Questions 1 to 9 must be completed if you are applying for **Term Life Insurance AND/OR Child Life and Accident Insurance.**

Questions 1 to 11 must be completed if you are applying for **Member Income Protection Insurance OR Office Overhead Expense Insurance.**

Has any individual (Member, Spouse or Child(ren)) proposed for coverage:

	MEMBER		SPOUSE		CHILD(REN)	
	YES	NO	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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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, skin disorder, gastrointestinal disorder or other illness not mentioned?	<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 or weakness, fibromyalgia or chronic pain, had X-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued on page 4

Underwriting Questionnaire (Continued) This page **MUST** be completed.

Has any individual (Member, Spouse or Child(ren)) proposed for coverage:

MEMBER		SPOUSE		CHILD(REN)	
YES	NO	YES	NO	YES	NO

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.), or been advised to undergo further investigation, see another doctor or have surgery?

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

Question #	Name of Proposed Insured	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:

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

11. **FEMALE MEMBER** applying for Income Protection Insurance only:
 Are you currently pregnant? Yes No If yes, give due date: _____
 Have you ever had a miscarriage, pre-eclampsia, Caesarean section or other complication of pregnancy? Yes No
 If yes, give date and details: _____

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.

Complete this section when applying for Member Income Protection OR Office Overhead Expense Insurance

- If self-employed, what is the organizational structure of your business? Sole Proprietor Partnership Corporation
- If owner of a partnership or corporation, give percentage ownership: _____ %
- Date you became self-employed: DD/MM/YYYY
- What is your share of Average Monthly Overhead Expenses, not including salary paid to yourself?
 (Complete only if applying for Office Overhead Expense Insurance): \$ _____
- Have you declared or are you contemplating personal or business bankruptcy? Yes No If yes, provide details including date of discharge:

Proof of Income: If applying for more than \$3,500/month of Income Protection Insurance, please submit pages 1, 2 and 3 of your last 2 years' tax returns. If incorporated, please also submit your last corporate financial statement.

Financial Information

(Complete only if total Term Life coverage per individual – applied for or existing – will exceed \$250,000 AND/OR if applying for Member Income Protection Insurance.)

<u>Member</u>		<u>Spouse</u>	
Annual Net Income, after expenses but before taxes	\$ _____	Annual Net Income, after expenses but before taxes	\$ _____
Personal Net Worth (assets less liabilities)	\$ _____	Personal Net Worth (assets less liabilities)	\$ _____

Québec residents only: After completion of pages 3 and 4, you may send them directly to Manulife Financial at the address shown on this document.

Method of Payment (Please select Option #1 or Option #2)

OPTION #1 Annual \$ X + = → \$ Amount Payable

Total Monthly Premium Number of Months to Sept. 1 (excluding present month) Provincial Sales Tax† (if applicable)

My cheque is enclosed and made payable to Manulife Financial.

OR

Charge to my: Visa MasterCard Card No. Expiry Date

OR

OPTION #2 Monthly \$ + \$ 2.00 + = → \$ Monthly Amount Payable

(by Pre-Authorized Debit-PAD) Enclose a sample cheque marked "VOID." Total Monthly Premium Service Charge Provincial Sales Tax† (if applicable)

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

Whether you choose monthly payment by PAD or annual payment by Credit Card or cheque, for your convenience your future premiums will automatically reflect this same payment method.

Payment Information

For Pre-Authorized Debit (PAD) payment options

Name of Account Holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Transit Number _____

Type of Account: Personal Chequing Chequing/Savings Savings Current Direct Deposit Account Other

Joint Accounts: Is this a joint account requiring only one signature? Yes No

If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

Payment Authorization

For Credit Card payment options

I/We hereby authorize Manulife Financial to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This Authorization may be terminated by either Manulife Financial or by me/us through written notice. Manulife Financial may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A \$25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

Second Signature If Joint Account _____ Dated _____ DD / MM / YYYY

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife Financial to withdraw monthly premiums from my bank account for insurance premiums due on or after the date I/we sign this authorization. I/We authorize Manulife Financial to withdraw premiums on or about the first business day of each month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. I/We waive the right to receive further notice of the amount and date of each automatic withdrawal. If my/our bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife Financial may attempt to withdraw that payment again within 30 days. Manulife Financial reserves the right to ask me/us for an alternate method of payment if my/our payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We and/or Manulife Financial can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Manulife Financial receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnipay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-668-0195, or e-mail am_service@manulife.com or write to us at Manulife Financial, PO Box 670, Str Waterlo, Waterloo, Ontario N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, you may contact your financial institution or visit www.cdnipay.ca.

Name of Account Holder _____ Signature of Account Holder _____

Second Signature If Joint Account _____ Dated _____ DD / MM / YYYY

Account Holder Address (If different from Applicant) _____

Terms & 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, including but not limited to the Underwriting Questionnaire originally attached hereto, 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 smoking status, shall render the insurance voidable at the instance of the insurer. Suicide within 2 years of the effective date is a risk not covered under the Term Life Plan. I/We understand that there are exclusions and limitations to the coverage applied for. I/We understand that insurance will take effect on the date the properly completed application (including my/our Underwriting Questionnaire) and payment of the first premium are received by Manulife Financial at its office, subject to approval of the insurer's underwriters. I/We understand that any health information must be accurate as at the date the application is signed.

AUTHORIZATION AND REVOCATION: 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, 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 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 this plan, to provide 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, 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 call or write to Manulife Financial at the address or telephone number shown on this application. A photocopy or faxed copy of this authorization shall be as valid as the original. I/We acknowledge receipt of and confirm my/our agreement with the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY (see Web Guide) and I (the Member) hereby designate the individual(s) named as beneficiary on this application to receive the proceeds payable upon my or my Spouse's death.

I/We declare that I/we 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 on 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/We 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.

I (the Member) hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any policy or certificate issued hereunder.

FOR QUEBEC 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.

_____	_____	DD/MM/YYYY
Member's Signature	Signed at (City/Town)	Date
_____	_____	DD/MM/YYYY
Spouse's Signature (if applying for Spouse coverage)	Signed at (City/Town)	Date

QUESTIONS? CALL MANULIFE FINANCIAL

TOLL-FREE: **1 800 668-0195** or e-mail: **am_service@manulife.com**

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

