

ASSOCIATION GROUP 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 YOUR PROFESSIONAL ASSOCIATION GROUP PLAN CAN PROVIDE, PLEASE REPLY TODAY!

Members and Spouses must be between 18 and less than 61 years of age. Eligible children are those unmarried, dependent on the member for support and over 14 days of age and under 21 or over 20 but less than 25 years of age if attending school or university full time. All applicants must be residing in Canada.

MEMBER INFORMATION

Name First Last Male Female

Unit/Apt. # No./Street City

Province Postal Code Tel. Res. () Bus. ()

E-mail† Date of Birth Day / Month / Year Country of Birth

Applicant is a member of: OR (specify in what capacity, in relation to the above Association/Society you are applying)

†Your e-mail address is important to us. At Manulife Financial we value your privacy. We do not sell or rent out our customer information. From time to time you may receive e-mails from us about new products and relevant information. Each time you receive an e-mail from us, you will have the option to opt out of our mailing list.

SPOUSE INFORMATION (if applying for spouse coverage)

Name First Last Male Female

Date of Birth Day / Month / Year Country of Birth Occupation If self-employed, please describe nature of business and duties.

BENEFICIARY INFORMATION

Beneficiary on Member Coverage Relationship

In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

Beneficiary on Spousal Coverage Relationship

The Member is the beneficiary for any spouse coverage unless indicated otherwise above.

BENEFITS APPLIED FOR AT THIS TIME (Do not include amounts already in force)

		AMOUNT OF COVERAGE
New Coverage <input type="checkbox"/>	Additional Coverage <input type="checkbox"/>	Certificate # <input type="text"/> (if currently insured)
Member Term Life Insurance Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/>	Indicate the amount you are applying for in \$25,000 increments. Minimum – \$50,000	
10% rate reduction on \$200,000 or more		= \$ <input type="text"/>
Spouse Term Life Insurance Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/>	Available only if you participate in the Member Term Life Plan. Minimum – \$50,000	
10% rate reduction on \$200,000 or more		= \$ <input type="text"/>
Child Term Life Insurance Available only if you participate in the Member Term Life Plan. Yes <input type="checkbox"/>	(One monthly premium of \$2.25 covers all your eligible children for \$10,000 of life coverage each.)	
Member Personal Accident Insurance Available if you participate in the Member Term Life Plan.	MONTHLY PREMIUM: Up to \$100,000 <input type="checkbox"/> \$6 Up to \$150,000 <input type="checkbox"/> \$9 Up to \$200,000 <input type="checkbox"/> \$12 Up to \$250,000 <input type="checkbox"/> \$15 <input type="checkbox"/> \$ <input type="text"/> other amount	
Spouse Personal Accident Insurance Available if you participate in the Spouse Term Life Plan.	MONTHLY PREMIUM: Up to \$100,000 <input type="checkbox"/> \$6 Up to \$150,000 <input type="checkbox"/> \$9 Up to \$200,000 <input type="checkbox"/> \$12 Up to \$250,000 <input type="checkbox"/> \$15 <input type="checkbox"/> \$ <input type="text"/> other amount	
Member Income Protection Insurance Choose a Benefit amount (\$100 - \$5000 per month) Waiting period <input type="text"/> days.	= \$ <input type="text"/>	
Office Overhead Expense Insurance Choose a Benefit amount (\$100 - \$5000 per month) Waiting period <input type="text"/> days.	= \$ <input type="text"/>	

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

UNDERWRITING QUESTIONNAIRE – PLEASE ANSWER ALL QUESTIONS

Member's Name (Please Print) Tel. # (Home)

Member's Physician Name Tel. # Date last seen (D/M/Y)

Reason for Visit Result

Spouse's Physician Name Tel. # Date last seen (D/M/Y)

Reason for Visit Result

Member's Height Weight Spouse's Height Weight

Has any individual proposed for coverage:

	Member		Spouse		Child(ren)	
	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), kidney disorder, urinary abnormality, unusual infection or immune system 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. Used drugs for other than medical purposes, been treated for or advised to reduce alcohol or drug use or used marijuana in the past 7 years? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had back, neck, hip or knee trouble or been treated for chronic pain or fibromyalgia, had X-rays of spine or joints or been hospitalized or disabled by any injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had any positive test, treatment for or exposure to HIV or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Female Applicants: Are you currently pregnant? If yes, give due date: <input type="text"/> (mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last 2 years, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flus, etc.), been advised to see another doctor or to have surgery or had an abnormal investigation or test result?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever engaged in or intend to engage in, any hazardous sport or activity, e.g., flying (except as a fare-paying passenger on a commercially licensed carrier), racing, scuba diving, climbing, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Smoked cigarettes in the last 12 months? (If other forms of tobacco used, give details.) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. 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"/>
10. Ever had his/her driver's licence suspended or been charged with impaired driving? If yes, provide driver's licence number: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Plan to reside outside of Canada? If yes, state country and date. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" answered to any question, give details below. If more space is needed, attach a separate page, signed and dated.

QUES. #	NAME TO BE INSURED	NATURE OF DISORDER	DURATION AND DATE	RESULT	ATTENDING PHYSICIAN AND/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. Results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health departments, if required by law.

