Manulife Financial

Group Benefits
Application for Insurance and Evidence of Insurability for Self-Administered Plans

INSTRUCTIONS - Please print all answers

1. Please consult your plan administrator for type of coverage available under your plan. Check (✓) to indicate the type of coverage for which you are applying.
◯ *PLAN MEMBER ONLY* ◯ *PLAN MEMBER AND SPOUSE* ◯ *PLAN MEMBER, SPOUSE AND DEPENDANTS* ◯ *SPOUSE AND/OR DEPENDANTS*

2. Please ensure that ALL SECTIONS are completed.
*Section 1 - Plan sponsor information - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR**.*
Sections 2, 3, 4, 5, 6 and 7 - Plan member/spouse information - To be completed by plan member/spouse and submitted to Manulife Financial.

3. If required, retain a photocopy for your files.

1 Plan sponsor information

Plan contract number(s)	Division number	Plan member certificate number	
		Class	**Annual earnings** $
Plan sponsor			Eligibility date (dd/mmm/yyyy)
Plan administrator name		Phone number	E-mail address
Plan member's name (last, first and middle initial)			Date of birth (dd/mmm/yyyy)
Language preference/Langue préférée ◯ English/Anglais ◯ French/Français	Sex ◯ Male ◯ Female		Province of residence

Coverage being applied for:

◯ Late entrant

◯ Extended health care coverage ◯ Single ◯ Family ◯ Dependant

◯ Dental coverage ◯ Single ◯ Family ◯ Dependant

◯ BASIC LIFE
Plan member's present amount of coverage $ _____
Additional amount requested $ _____
Total amount requested $ _____

◯ LTD/OPT LTD
Plan member's present amount of coverage $ _____
Additional amount requested $ _____
Total amount requested $ _____

◯ STD
Plan member's present amount of coverage $ _____
Additional amount requested $ _____
Total amount requested $ _____

◯ LTD Option: From _____ To _____ LIFE Option: From _____ To _____

◯ OPTIONAL LIFE ◯ Dollar amount OR ◯ Unit amount OR ◯ Salary amount

Optional life amount:
Plan member's present amount of optional life $ _____ OR ___ units of $ _____ OR ___ x salary $ _____ = $ _____
Additional amount requested $ _____ OR ___ units of $ _____ OR ___ x salary $ _____ = $ _____
Total amount requested $ _____ OR ___ units of $ _____ OR ___ x salary $ _____ = $ _____

Spousal optional life amount: ◯ Dollar amount OR ◯ Unit amount OR ◯ Salary amount
Spouse's present amount of optional life $ _____ OR ___ units of $ _____ OR ___ x salary $ _____ = $ _____
Additional amount requested $ _____ OR ___ units of $ _____ OR ___ x salary $ _____ = $ _____
Total amount requested $ _____ OR ___ units of $ _____ OR ___ x salary $ _____ = $ _____

◯ DEPENDANT LIFE
Dependant life amount: $ _____

◯ Other: (specify)

Signature of plan administrator	Date signed (dd/mmm/yyyy)

2 Plan member statement

Plan member's name (last, first and middle initial) | Occupation

Sex ◯ Male ◯ Female | Date of birth (dd/mmm/yyyy) | Home phone number | Business phone number Ext.

Plan member's address (number, street, apartment)

City | Province | Postal code

Height _____ m _____ cm _____ ft _____ in | Weight ◯ kg ◯ lb | Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite) | Physician's phone number

City | Province | Postal code

3 Spouse statement

Spouse's name (last, first and middle initial)

Sex ◯ Male ◯ Female | Date of birth (dd/mmm/yyyy) | Home phone number | Business phone number Ext.

Height _____ m _____ cm _____ ft _____ in | Weight ◯ kg ◯ lb | Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

Have you lost or gained more than 10 lbs. during the last 12 months? ◯ Yes ◯ No If "Yes", please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason

Is name of personal physician the same as member? ◯ Yes ◯ No If "No," please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite) | Physician's phone number

City | Province | Postal code

4 Dependant statement

To be completed when dependants are applying for coverage.

Please provide the following information for each dependant to be insured.

Complete name of eligible Dependant	Sex	Relationship to plan member	Date of birth (dd/mmm/yyyy)	Height ◯ m ◯ cm ◯ ft ◯ in	Weight ◯ kg ◯ lbs
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				

Is name of personal physician the same as member? ◯ Yes ◯ No If "No," please provide:

Name of personal physician (last, first and middle initial)

Address of personal physician (number, street, suite) | Physician's phone number

City | Province | Postal code

5 Medical questions for proposed insured

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers please attach a separate sheet (signed and dated).

	Plan member	Spouse	Children
1. During the past 12 months have you			
(a) flown as a pilot, student pilot or crew member or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you			
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) been absent from work for medical reasons during the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) currently received any treatment/medications?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(f) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you ever consulted a physician, ever been treated for, or had any known identification of			
(a) chest pain, blood vessel disease, heart disorder, or heart attack or stroke?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) high blood pressure?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinsons)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(g) excessive use of alcohol or drugs?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(h) lung disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(i) bowel, stomach or liver disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(j) cancer?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(k) disorder of the kidney, urine or genital organs?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(l) arthritis, rheumatism or fibromyalgia?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(m) disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(n) immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(o) anemia, or other blood disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Please provide details below, if you have answered "Yes" to *ANY* questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

Question number	Name of person (first & middle initial)	Details or name of condition	Date and duration	Medication/treatment and results (recovery or remaining effects)	Names and addresses of physicians and hospitals

6 Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan member's name	
Plan member's signature	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date signed (dd/mmm/yyyy)

Print

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

7 Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1