Manulife Financial

Group Benefits
Evidence of Insurability

INSTRUCTIONS - Please print all answers

1. Please consult Manulife Financial 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.

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

1 Plan sponsor information

Plan number(s)	Division number	Plan member certificate number
		Plan sponsor
Plan administrator name (last, first and middle initial)	Phone number ( )	E-mail address

2 Plan member statement

Plan member name (last, first and middle initial)			Occupation
Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)	Home phone number ( )	Business phone number ( )
Plan member address (street 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 (suite/street number, street, apartment)		Physician's phone number ( )
City	Province	Postal code

3 Spousal statement

Spouse's name (last, first and middle initial)			
Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)	Home phone number ( )	Business phone number ( )
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 (suite/street number, street, apartment)		Physician's phone number ( )
City	Province	Postal code

4 Dependant statement

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

If you have more than three children, please attach separate sheet (signed and dated) and include all personal information as requested above.

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

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

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 (suite/street number, street, apartment) | Physician's phone number ( )

City | Province | Postal code

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

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

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 (suite/street number, street, apartment) | Physician's phone number ( )

City | Province | Postal code

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

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

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 (suite/street number, street, apartment) | 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. Do you currently participate in any hazardous sport activity, such as SCUBA diving, piloting aircraft, auto racing, etc.? Please specify which activity: _____	◯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) are you currently receiving any treatment?	◯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?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(b) high blood pressure, stroke?	◯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, nervous or mental illness, or an emotional condition such as anxiety or depression?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(f) excessive use of alcohol or drugs?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(g) lung disorders?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(h) bowel disorders, stomach or liver disorders?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(i) cancer?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(j) disorder of the kidney, urine or genital organs?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(k) arthritis or rheumatism?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(l) disorders of the muscles or bones including the back, spine or joints?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
(m) 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
(n) 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 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)	Details or name of condition	Date and duration	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.

Signature of plan member	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)

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
P O BOX 2026
HALIFAX NS B3J 2Z1