Manulife Financial

Group Benefits
e-Application and Evidence of Insurability for Optional Life Insurance

INSTRUCTIONS - Please print all answers

1. Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box 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's information - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR**.*
Sections 2, 3, 4, 5, 6, 7 and 8 - 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's information

Plan contract number(s)	Division number	Plan member certificate number	
		Class	**Annual earnings** **$**
Plan sponsor			Eligibility date (dd/mmm/yyyy)

Optional life amount: ◯ Dollar amount OR ◯ Unit amount OR ◯ Salary 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 optional life amount: ◯ Dollar amount OR ◯ Unit amount

Dependant's present amount of optional life $____ OR ___ units of $____

Additional amount requested $____ OR ___ units of $____

Total amount requested $____ OR ___ units of $____

Plan administrator name	Date signed (dd/mmm/yyyy)
Phone number	Email address

2 Plan member statement

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

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

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 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

Note: If living, you will be the beneficiary of your spouse and/or dependant's insurance; otherwise the beneficiary will be your estate.

For designated beneficiaries under the age of majority.

Name of beneficiary (last, first and middle initial)	Relationship to plan member	Percentage of benefit
		%
Name of beneficiary (last, first and middle initial)	Relationship to plan member	Percentage of benefit
		%
Name of beneficiary (last, first and middle initial)	Relationship to plan member	Percentage of benefit
		%
	TOTAL	100%

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

Irrevocability

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

4 Spouse statement

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

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

Height	Weight	Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months?
_____ m _____ cm _____ ft _____ in	◯ kg ◯ lb	◯ 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?	Was this a gain or a loss?	Reason
◯ kg ◯ lb		

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 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

6 Medical questionnaire

	Plan member	Spouse	Children
1. Have you, within the last three (3) years, had an application for life or health insurance declined, postponed or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you, within the last three (3) years, consulted a physician, or been treated, for high blood pressure, chest pain, heart attack, heart murmur, stroke, cancer, tumour, ulcer, colitis, diabetes, asthma, epilepsy, back pain, nervous or mental illness, an emotional condition, anxiety or depression, urinary tract infection, sexually transmitted disease, alcoholism, drug addiction, or any disease or disorder of the heart, blood, lungs, liver, kidneys, or urine?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you, within the last three (3) years, been told that you had any immune deficiency disorder, including AIDS or AIDS RELATED COMPLEX (ARC), or any generalized enlargement of your lymph glands, or any test results indicating possible exposure to the AIDS virus (e.g. HIV, HTLV-III, LAV)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you had surgery or been hospitalized within the past three years?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
5. Have you consulted a physician or other practitioner within the past sixty days and been advised to have further treatment, examination, diagnostic test, or surgery not already performed?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
6. Have you, during the last five (5) years had X-rays, Electrocardiograms, blood or other special tests, for other than regular medical checkups, taken or currently on any treatment/medication?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
7. 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
8. During the past 12 months have you, your spouse or your dependants: (a) flown as a pilot, student pilot or crew member or have any intention of doing so? (b) ever engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so? Please specify which activity. _____	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ 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

7 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 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)

Mail to...

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.

8 Mailing instructions

Please send the completed form to:

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

La version française du document se trouve à l'adresse www.manuvie.ca/assurancecollective