



# Personal Critical Illness

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- **Application**
- **Evidence of Insurability**
  - Complete only if applying for a total coverage amount over \$25,000
- **Payment Information**
- **Certification and Authorization**

## **The Manufacturers Life Insurance Company (Manulife)**

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## Group Benefits

### Personal Critical Illness Application

#### Conditions for eligibility

By signing the Authorization section of this Application on page 9 of 10, I signify my understanding and acknowledgement that in order to qualify for coverage in amounts of \$25,000 or less that do not require the completion of a detailed medical questionnaire, the person(s) whom I seek to insure under this application (myself, my spouse, my child(ren) or any one of us) must be in good health ("Good Health"), and accordingly, I **declare** that the person(s) whom I seek to insure is (are) in Good Health and more specifically, that any adult(s) to be insured does (do) not have any physical or mental conditions that prevent them:

- (a) if they are employed, from regularly attending to their occupation, or
  - (b) if they are not employed, from being so employed if they chose to engage in an occupation; and
- that the person(s) whom I seek to insure has (have) never been declined when they have either applied for or been the subject of any application for life insurance or critical illness insurance coverage with any insurer, or other entity. I also **understand and acknowledge** that where this application is approved by Manulife, the contract issued to me will contain an exclusion under which benefits will not be paid for any pre-existing medical conditions, as defined in the contract.

#### Instructions:

1. Please consult your plan administrator for the policy number and certificate number, if applicable.
2. Please print in ink.
3. **Please retain a photocopy for your files.**

|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|------------------------------------|------------------------------------------------|----------------------------------------------------------------|------------------------------------|-----------------------------|----------------------------------------------------------------|------------------------------------|-----------------------------|----------------------------------------------------------------|------------------------------------------------------|--|--|------|----------|-------------|---------------|--|
| <b>1a) Plan member information</b><br><br>Required if applying for member, spousal or child coverage | <table border="1"> <tr> <td>Policy number(s)</td> <td>Plan member certificate number</td> <td colspan="2">Plan sponsor/employer name</td> </tr> <tr> <td colspan="4">Plan member name (first, middle initial, last)</td> </tr> <tr> <td>Sex<br/><input type="radio"/> Male <input type="radio"/> Female</td> <td>Date of birth (dd/mmm/yyyy)</td> <td>Home phone number</td> <td>Business phone number</td> </tr> <tr> <td colspan="3">Plan member's address (number, street and apartment)</td> <td>City</td> </tr> <tr> <td>Province</td> <td>Postal code</td> <td colspan="2">Email address</td> </tr> </table> <p>By providing my personal email address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.</p> | Policy number(s)                                               | Plan member certificate number                                 | Plan sponsor/employer name                                     |                                    | Plan member name (first, middle initial, last) |                                                                |                                    |                             | Sex<br><input type="radio"/> Male <input type="radio"/> Female | Date of birth (dd/mmm/yyyy)        | Home phone number           | Business phone number                                          | Plan member's address (number, street and apartment) |  |  | City | Province | Postal code | Email address |  |
| Policy number(s)                                                                                     | Plan member certificate number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Plan sponsor/employer name                                     |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Plan member name (first, middle initial, last)                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Sex<br><input type="radio"/> Male <input type="radio"/> Female                                       | Date of birth (dd/mmm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Home phone number                                              | Business phone number                                          |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Plan member's address (number, street and apartment)                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                | City                                                           |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Province                                                                                             | Postal code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Email address                                                  |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| <b>1b) Personal critical illness amount</b><br><br>Required if applying for member coverage          | <p><b>Available in multiples of \$5,000 with a minimum \$10,000 up to \$150,000.</b></p> <p>Are you applying for the first time? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, amount requested \$ _____</p> <p>If no, additional amount requested \$ _____</p> <p>Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? <input type="radio"/> Yes <input type="radio"/> No</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| <b>2 Spousal information</b><br><br>Only required if applying for spousal coverage                   | <table border="1"> <tr> <td>Spouse's name (first, middle initial, last)</td> <td>Sex<br/><input type="radio"/> Male <input type="radio"/> Female</td> <td>Date of birth (dd/mmm/yyyy)</td> </tr> </table> <p><b>Spousal life amount</b><br/><b>Available in multiples of \$5,000 with a minimum \$10,000 up to \$150,000.</b></p> <p>Are you applying for the first time? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, amount requested \$ _____</p> <p>If no, additional amount requested \$ _____</p> <p>Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? <input type="radio"/> Yes <input type="radio"/> No</p>                                                                                                                                                                                                                                                                                                                                        | Spouse's name (first, middle initial, last)                    | Sex<br><input type="radio"/> Male <input type="radio"/> Female | Date of birth (dd/mmm/yyyy)                                    |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Spouse's name (first, middle initial, last)                                                          | Sex<br><input type="radio"/> Male <input type="radio"/> Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Date of birth (dd/mmm/yyyy)                                    |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| <b>3 Child information</b><br><br>Only required if applying for coverage for child(ren)              | <p><b>Child life amount:</b><br/> <input type="radio"/> \$10,000 benefit applies to all eligible dependent children under age 21.</p> <p>Provide details for all children under age 21.</p> <table border="1"> <tr> <td>Name (first, middle initial, last)</td> <td>Date of birth (dd/mmm/yyyy)</td> <td>Sex<br/><input type="radio"/> Male <input type="radio"/> Female</td> </tr> <tr> <td>Name (first, middle initial, last)</td> <td>Date of birth (dd/mmm/yyyy)</td> <td>Sex<br/><input type="radio"/> Male <input type="radio"/> Female</td> </tr> <tr> <td>Name (first, middle initial, last)</td> <td>Date of birth (dd/mmm/yyyy)</td> <td>Sex<br/><input type="radio"/> Male <input type="radio"/> Female</td> </tr> <tr> <td>Name (first, middle initial, last)</td> <td>Date of birth (dd/mmm/yyyy)</td> <td>Sex<br/><input type="radio"/> Male <input type="radio"/> Female</td> </tr> </table>                                                                                                                                                                | Name (first, middle initial, last)                             | Date of birth (dd/mmm/yyyy)                                    | Sex<br><input type="radio"/> Male <input type="radio"/> Female | Name (first, middle initial, last) | Date of birth (dd/mmm/yyyy)                    | Sex<br><input type="radio"/> Male <input type="radio"/> Female | Name (first, middle initial, last) | Date of birth (dd/mmm/yyyy) | Sex<br><input type="radio"/> Male <input type="radio"/> Female | Name (first, middle initial, last) | Date of birth (dd/mmm/yyyy) | Sex<br><input type="radio"/> Male <input type="radio"/> Female |                                                      |  |  |      |          |             |               |  |
| Name (first, middle initial, last)                                                                   | Date of birth (dd/mmm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sex<br><input type="radio"/> Male <input type="radio"/> Female |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Name (first, middle initial, last)                                                                   | Date of birth (dd/mmm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sex<br><input type="radio"/> Male <input type="radio"/> Female |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Name (first, middle initial, last)                                                                   | Date of birth (dd/mmm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sex<br><input type="radio"/> Male <input type="radio"/> Female |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |
| Name (first, middle initial, last)                                                                   | Date of birth (dd/mmm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Sex<br><input type="radio"/> Male <input type="radio"/> Female |                                                                |                                                                |                                    |                                                |                                                                |                                    |                             |                                                                |                                    |                             |                                                                |                                                      |  |  |      |          |             |               |  |

## Group Benefits

### Personal Critical Illness Evidence of Insurability

**Complete only if applying for a total coverage amount over \$25,000.**

The following questions should be answered by each individual applying for coverage that needs to provide evidence of insurability as part of your application. If more space is needed, use another form or sheet of paper (both must be signed and dated).

|                         |                                                |  |                                                                            |                                                                            |
|-------------------------|------------------------------------------------|--|----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>For Manulife use</b> | Policy number(s)                               |  | Plan member certificate number                                             |                                                                            |
|                         | Plan member name (first, middle initial, last) |  | Member<br><input type="radio"/> Smoker<br><input type="radio"/> Non-smoker | Spouse<br><input type="radio"/> Smoker<br><input type="radio"/> Non-smoker |

  

|                                                                                                                      |                                                          |                                                                |                                                                                                                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1 a) Plan member basic medical information</b><br><br>Only required if applying for total coverage over \$100,000 | Height<br>_____ m _____ cm<br>_____ ft _____ in          | Weight<br><input type="radio"/> kg<br><input type="radio"/> lb | Any weight change greater than 4.5 kg/10 pounds in the last 12 months?<br><input type="radio"/> No <input type="radio"/> Yes Gain/loss _____ <input type="radio"/> kg <input type="radio"/> lb<br>Reason: _____ |  |
|                                                                                                                      | Name of personal physician (first, middle initial, last) |                                                                | Physician's phone number                                                                                                                                                                                        |  |
|                                                                                                                      | Date of last visit (dd/mm/yyyy)                          | Reason                                                         |                                                                                                                                                                                                                 |  |
|                                                                                                                      | Address of personal physician (number, street and suite) |                                                                |                                                                                                                                                                                                                 |  |
|                                                                                                                      | City                                                     | Province                                                       | Postal code                                                                                                                                                                                                     |  |

  

|                                                                                                                        |                                                          |                                                                |                                                                                                                                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1 b) Spouse basic medical information</b><br><br>Only required if applying for total spousal coverage over \$25,000 | Height<br>_____ m _____ cm<br>_____ ft _____ in          | Weight<br><input type="radio"/> kg<br><input type="radio"/> lb | Any weight change greater than 4.5 kg/10 pounds in the last 12 months?<br><input type="radio"/> No <input type="radio"/> Yes Gain/loss _____ <input type="radio"/> kg <input type="radio"/> lb<br>Reason: _____ |  |
|                                                                                                                        | Name of personal physician (first, middle initial, last) |                                                                | Physician's phone number                                                                                                                                                                                        |  |
|                                                                                                                        | Date of last visit (dd/mm/yyyy)                          | Reason                                                         |                                                                                                                                                                                                                 |  |
|                                                                                                                        | Address of personal physician (number, street and suite) |                                                                |                                                                                                                                                                                                                 |  |
|                                                                                                                        | City                                                     | Province                                                       | Postal code                                                                                                                                                                                                     |  |

  

|                                |                                                                                                                                                                                                                                                                                                  |                   |                                                                   |                                                              |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------|--------------------------------------------------------------|
| <b>2 Medical questionnaire</b> | <b>IMPORTANT:</b> Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis. |                   |                                                                   |                                                              |
|                                | A. Have you ever had an application for any insurance that was declined, postponed or rated in any way?<br>If answered yes, please provide details.                                                                                                                                              |                   | Plan member<br><input type="radio"/> Yes <input type="radio"/> No | Spouse<br><input type="radio"/> Yes <input type="radio"/> No |
| Name of person                 |                                                                                                                                                                                                                                                                                                  | Date (dd/mm/yyyy) | Reason                                                            |                                                              |

## 2 Medical questionnaire (continued)

Plan member

Spouse

B. Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment, care or been advised to receive care or have further treatment for:

1) AIDS, a positive HIV test or AIDS-related disease?

☐ Yes ☐ No

☐ Yes ☐ No

2) Diabetes?

☐ Yes ☐ No

☐ Yes ☐ No

3) Multiple sclerosis?

☐ Yes ☐ No

☐ Yes ☐ No

4) Organ transplant?

☐ Yes ☐ No

☐ Yes ☐ No

5) Hepatitis or hepatitis carrier state, other than Hep A?

☐ Yes ☐ No

☐ Yes ☐ No

6) Stroke or transient ischemic attack (TIA)?

☐ Yes ☐ No

☐ Yes ☐ No

7) Alzheimer's disease or Parkinson's disease?

☐ Yes ☐ No

☐ Yes ☐ No

8) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?

☐ Yes ☐ No

☐ Yes ☐ No

9) Motor neuron diseases, including but not limited to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)?

☐ Yes ☐ No

☐ Yes ☐ No

10) Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congestive heart failure, arrhythmia, peripheral vascular disease, or aneurysm?

☐ Yes ☐ No

☐ Yes ☐ No

11) Paralysis? If answered yes, please provide details.

☐ Yes ☐ No

☐ Yes ☐ No

Name of person

Is it trauma related?

☐ Yes ☐ No

☐ Local or ☐ General paralysis

Details

12) Chest pain? If answered yes, please provide details.

☐ Yes ☐ No

☐ Yes ☐ No

Name of person

Date (dd/mm/yyyy)

Cause

Diagnosis

Status

Treatment

13) Congenital heart disorder? If answered yes, please provide details.

☐ Yes ☐ No

☐ Yes ☐ No

Name of person

Date (dd/mm/yyyy)

Cause

Diagnosis

Status

Treatment

14) Heart murmur, shortness of breath, irregular heart beat, any disorder of the blood?  
If answered yes, please provide details.

☐ Yes ☐ No

☐ Yes ☐ No

Name of person

Date (dd/mm/yyyy)

Cause

Diagnosis

Status

Treatment

15) Lymph, glandular disorder, or thyroid disorder? If answered yes, please provide details.

☐ Yes ☐ No

☐ Yes ☐ No

Name of person

Date (dd/mm/yyyy)

Diagnosis

Status

Treatment

## 2 Medical questionnaire (continued)

|                                                                                                                                                                                                                                                                   |  |                                                                        | Plan member                                        | Spouse                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| 16) Disorder of the eye or ear leading to blindness or deafness? If answered yes, please provide details.                                                                                                                                                         |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date (dd/mmm/yyyy)                                                     |                                                    |                                                    |
| Diagnosis                                                                                                                                                                                                                                                         |  | Status                                                                 |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                         |  |                                                                        |                                                    |                                                    |
| 17) Alcohol or drug abuse? If answered yes, please provide details.                                                                                                                                                                                               |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date (dd/mmm/yyyy) and duration                                        |                                                    |                                                    |
| Treatment and results                                                                                                                                                                                                                                             |  |                                                                        |                                                    |                                                    |
|                                                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |
| 18) Disorder of the brain or nervous system, neurological disorder, epilepsy, optic neuritis, blurred or double vision, memory loss, weakness, tremor, numbness or tingling, impaired balance, loss of consciousness?<br>If answered yes, please provide details. |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date of onset (dd/mmm/yyyy)                                            | Date of last symptoms (dd/mmm/yyyy)                |                                                    |
| Diagnosis                                                                                                                                                                                                                                                         |  | Status                                                                 |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                         |  |                                                                        |                                                    |                                                    |
| Name and address of doctor seen                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |
| 19) Cancer, leukemia, Hodgkin's disease or other malignancy?                                                                                                                                                                                                      |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date (dd/mmm/yyyy)                                                     | Type                                               |                                                    |
| Location on body                                                                                                                                                                                                                                                  |  | Status<br><input type="radio"/> Benign <input type="radio"/> Malignant |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                         |  |                                                                        |                                                    |                                                    |
|                                                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |
| 20) Growths, cysts or tumour? If answered yes, please provide details.                                                                                                                                                                                            |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date (dd/mmm/yyyy)                                                     | Type                                               |                                                    |
| Location on body                                                                                                                                                                                                                                                  |  | Status<br><input type="radio"/> Benign <input type="radio"/> Malignant |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                         |  |                                                                        |                                                    |                                                    |
|                                                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |
| 21) Dysplastic nevi or moles? If answered yes, please provide details.                                                                                                                                                                                            |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date (dd/mmm/yyyy)                                                     | Type                                               |                                                    |
| Location on body                                                                                                                                                                                                                                                  |  | Status<br><input type="radio"/> Benign <input type="radio"/> Malignant |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                         |  |                                                                        |                                                    |                                                    |
|                                                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |
| 22) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs?<br>If answered yes, please provide details.                                                                                                      |  |                                                                        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                    |  | Date of onset (dd/mmm/yyyy)                                            | Date of last symptoms (dd/mmm/yyyy)                |                                                    |
| Diagnosis                                                                                                                                                                                                                                                         |  | Status                                                                 |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                         |  |                                                                        |                                                    |                                                    |
|                                                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |
| Name and address of doctor seen                                                                                                                                                                                                                                   |  |                                                                        |                                                    |                                                    |

## 2 Medical questionnaire (continued)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |           |                   |                              | Plan member                                        | Spouse                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------|-------------------|------------------------------|----------------------------------------------------|----------------------------------------------------|
| C. 1) Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, diabetes (2 or more family members prior to age 50), chronic kidney disease, angina, stroke, multiple sclerosis, Huntington's disease, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60?<br>If answered yes, please provide details in the chart below. |              |           |                   |                              | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Plan member or spouse's family member                                                                                                                                                                                                                                                                                                                                                                                                                                 | Relationship | Condition | Age at onset      | Age at death (if applicable) |                                                    |                                                    |
| <input type="radio"/> Member<br><input type="radio"/> Spouse                                                                                                                                                                                                                                                                                                                                                                                                          |              |           |                   |                              |                                                    |                                                    |
| <input type="radio"/> Member<br><input type="radio"/> Spouse                                                                                                                                                                                                                                                                                                                                                                                                          |              |           |                   |                              |                                                    |                                                    |
| <input type="radio"/> Member<br><input type="radio"/> Spouse                                                                                                                                                                                                                                                                                                                                                                                                          |              |           |                   |                              |                                                    |                                                    |
| <input type="radio"/> Member<br><input type="radio"/> Spouse                                                                                                                                                                                                                                                                                                                                                                                                          |              |           |                   |                              |                                                    |                                                    |
| 2) If you have a family history of breast or ovarian cancer, have you had a breast exam, mammogram or other investigation? If answered yes, please provide details.                                                                                                                                                                                                                                                                                                   |              |           |                   |                              | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |           | Date (dd/mm/yyyy) |                              |                                                    |                                                    |
| Results                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |           |                   |                              |                                                    |                                                    |
| 3) If you have a family history of colon cancer, have you had a colonoscopy? If answered yes, please provide details.                                                                                                                                                                                                                                                                                                                                                 |              |           |                   |                              | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |           | Date (dd/mm/yyyy) |                              |                                                    |                                                    |
| Results                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |           |                   |                              |                                                    |                                                    |
| D. During the last 5 years, have you had any abnormal result of any of the following: EKG, stress EKG, echocardiograms, mammogram, Pap smear (exclude if 2 subsequent Pap smears have been normal), PSA, sigmoidoscopy, colonoscopy, biopsy? If answered yes, please provide details.                                                                                                                                                                                 |              |           |                   |                              | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | Test type | Date (dd/mm/yyyy) |                              |                                                    |                                                    |
| Test results                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |           | Status            |                              |                                                    |                                                    |
| Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |           |                   |                              |                                                    |                                                    |
| E. Other than for a common cold, osteoarthritis, bone fractures, have you had an abnormal result of any of the following: X-ray, CAT scan, or MRI? If answered yes, please provide details.                                                                                                                                                                                                                                                                           |              |           |                   |                              | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | Test type | Date (dd/mm/yyyy) |                              |                                                    |                                                    |
| Test results                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |           | Status            |                              |                                                    |                                                    |

|                                                                                                                                                                                                          |                      |                                                    |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------|----------------------------------------------------|
| <b>2 Medical questionnaire (continued)</b>                                                                                                                                                               |                      | <b>Plan member</b>                                 | <b>Spouse</b>                                      |
| F. <b>Have you ever had elevated blood pressure or cholesterol?</b> If answered <i>yes</i> , please provide details.                                                                                     |                      | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                           | Date (dd/mm/yyyy)    |                                                    |                                                    |
| Most recent results                                                                                                                                                                                      | Is it under control? |                                                    |                                                    |
| Treatment                                                                                                                                                                                                |                      |                                                    |                                                    |
| G. <b>Are you aware of any symptoms or complaints for which you have not sought treatment or advice, or are you awaiting any tests or test results?</b> If answered <i>yes</i> , please provide details. |                      | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Name of person                                                                                                                                                                                           |                      |                                                    |                                                    |
| Details                                                                                                                                                                                                  |                      |                                                    |                                                    |

## Group Benefits

### Personal Life Payment Information

Premium amount(s) are specified in your contract and may change over time. Please ensure funds are available in your account at the time of the application as your premium is due the 1<sup>st</sup> of the month following approval. If more than one month of premium is due that amount will be withdrawn from your account.

|                         |                                                |  |                    |  |
|-------------------------|------------------------------------------------|--|--------------------|--|
| <b>For Manulife use</b> | Policy number(s)                               |  | Certificate number |  |
|                         | Plan member name (first, middle initial, last) |  |                    |  |

  

|                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                                                                   |                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------|----------------|--|
| <b>Monthly payment by pre-authorized debit (PAD)</b><br><br>For verification purposes we require a VOID cheque.                                                                                                                                                                        | <b>Select one of the following:</b><br><input type="radio"/> Personal PAD <input type="radio"/> Business PAD                                                                                                                                                                                                                                                                                                                                        |                |                                                                   |                |  |
|                                                                                                                                                                                                                                                                                        | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">  <p>500 KING ST. NORTH<br/>WATERLOO, ONTARIO N2J 4C6</p> <p>MEMO _____</p> </div> <div style="width: 50%;"> <p>The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.</p> </div> </div> |                |                                                                   |                |  |
|                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                   |                |                                                                   |                |  |
|                                                                                                                                                                                                                                                                                        | Transit number                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Institution number                                                | Account number |  |
|                                                                                                                                                                                                                                                                                        | Name of account holder                                                                                                                                                                                                                                                                                                                                                                                                                              |                |                                                                   |                |  |
| Name of financial institution                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | Type of account                                                   |                |  |
|                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                | <input type="radio"/> Chequing <input type="radio"/> Non-chequing |                |  |
| Transit number                                                                                                                                                                                                                                                                         | Institution number                                                                                                                                                                                                                                                                                                                                                                                                                                  | Account number |                                                                   |                |  |
| <b>Joint accounts:</b> Is this a joint account requiring only one signature? <input type="radio"/> Yes <input type="radio"/> No<br>If more than one signature is required on withdrawals issued against the account, both account holders must sign the authorization on page 9 of 10. |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                                                                   |                |  |
| <b>Non-chequing accounts:</b> For accounts with no chequing privileges, Manulife requires validation from your financial institution (e.g. withdrawal slip with official stamp) in order to begin the pre-authorized payment process.                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                                                                   |                |  |

## Group Benefits

### Personal Critical Illness Certification and Authorization

#### 1 Certification and authorization

**I certify** that I, being the plan member with the capacity to contract, am applying for this personal benefits coverage/insurance ("Coverage") and that all information provided in support of 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 support of this application. **I authorize** Manulife to collect, use, maintain and disclose my personal information and personal health information including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, relevant to this application ("Information") for the purposes of the assessment, investigation and/or management of this application, including but not limited to medical underwriting; and where Coverage is issued, the administration, audit and management of my Coverage and the investigation of any claims made thereunder, including my participation in any independent medical assessments (collectively, the "Purposes"). **I understand** that I am responsible for any fees related to the completion of this application. Where this application pertains to one of my Dependents (spouse and/or child) **I certify that I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any such Dependents, for the Purposes. **I authorize** any person or organization with Information including, but not limited to, any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other 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 hereby authorize** the use of my Social Insurance Number ("SIN"), where my SIN is used as my certificate number, for the purposes of identification and administration of this application and any Coverage, and for the facilitation of any pre-authorized collection.

**I authorize** Manulife to withdraw, until further written notice from me or my duly authorized representative, all premium payments ("Payments") due in relation to the Coverage from the bank account identified on the attached void cheque (referred to herein as the "Account") on or about the first business day of each month in which Coverage premiums are due. **I also understand and agree** that either Manulife or I may, at any time upon written notice, discontinue the direct withdrawal of Payment(s), from my Account, in which case Manulife shall be entitled to require another method of payment, acceptable to Manulife. The terms and conditions of this pre-authorized collection authorization shall apply to the Accounts herein named by me and any other Accounts I choose to name in the future, and shall remain valid for the duration of my Coverage or until revoked by me in writing. **I agree** that if I have asked Manulife to debit my bank account for a Pre-authorized Debit (PAD) plan (Personal or Business PAD), **I authorize** the bank or other financial institution I have named to honour my instructions. 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 understand** that Manulife or I may terminate a PAD plan by giving 10 days written notice, beginning on the date the notice is mailed. **I understand** that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights or cancellation rights, I may contact Manulife, my financial institution or visit [www.payments.ca](http://www.payments.ca) for more information.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not yet guaranteed as a secured means of communication.

**I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife.

**I understand** that if I do not wish to receive Information (or other materials related Manulife products and services) from Manulife through the email address identified on this form that I may contact the Customer Service Centre to opt-out of receiving this information.

**I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that Manulife's Privacy Policy is available upon request or at [www.manulife.ca](http://www.manulife.ca)

|                                                                                                                |                           |
|----------------------------------------------------------------------------------------------------------------|---------------------------|
| Signature of plan member                                                                                       | Date signed (dd/mmm/yyyy) |
| Signature of spouse (required only if the Evidence of Insurability has been completed on behalf of the spouse) | Date signed (dd/mmm/yyyy) |
| Signature of account holder, if different from plan member                                                     | Date signed (dd/mmm/yyyy) |
| Signature of joint account holder (if applicable)                                                              | Date signed (dd/mmm/yyyy) |

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a personal benefits 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.

**Please complete next page.**

## **2 Mailing instructions**

Please send the completed form and, if applicable, VOID cheque to:

**Group Medical Underwriting**

**Manulife**

**PO BOX 1900, STATION C**

**KITCHENER ON N2G 4R4**

**Phone: 1-866-318-2727**