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The Manufacturers Life Insurance Company

**All applicants must complete Parts A, B, C, D and E and sign the Applicant's Declaration and Authorization.*

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Advisor ID: ______

Advisor Name: ______

Advisor Email: ______

Part A • General Information

Applicant's Last Name ______ First Name ______ Initial ____ Health Card Number | | | | | | | | | | | | |

Apt. Number ______ Street Number and Name ______ Telephone (   ) ______

City or Town ______ Province ______ Postal Code ______ Occupation ______

Applicant is a Member of: ______ Membership No. ______

Co-Applicant's Last Name ______ First Name ______ Co-Applicant's Occupation ______

Applicant's Office Telephone (   ) ______ Co-Applicant's Office Telephone (   ) ______

Applicant's Email ______ Co-Applicant's Email ______

If additional information is required, how may we contact you? ❑ Phone ❑ Office ❑ Email Best time to call ______ AM PM

Are you now covered by or did you recently have group health insurance coverage? ❑ Yes ❑ No

If "Yes", please indicate:

Group Plan Number ______ ID Number ______

Insurance Company ______ Date Benefits Ended ______ (DD/MM/YYYY)

Group Plan Number ______ ID Number ______

Insurance Company ______ Date Benefits Ended ______ (DD/MM/YYYY)

Note for Quebec residents: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

The Professional Retiree Health & Dental Plan

***All applicants must complete Parts A, B, C, D and E**
***All applicants must complete and sign the Declaration and Authorization section.**

Part B • Plan Choice

Remember: Your Plan Choice applies to all family members.

I/We apply for:

❑ **Base Plan**

The Base option does **not** require completion of the Medical Questionnaire (Parts F & G) of this application.

❑ **Bridge Plan**

Completion of the Medical Questionnaire (Parts F & G) of this application is required if you apply more than 60 days after leaving a group plan or have never been covered by a group plan.

❑ **Comprehensive Plan**

Completion of the Medical Questionnaire (Parts F & G) of this application is required.

Part C • Individuals To Be Covered

LAST NAME	FIRST NAME	HEALTH CARD NO.	CODE	SEX	BIRTH DATE DD MM YYYY	AGE	SMOKER IN THE PAST 12 MONTHS? NO. OF CIGARETTES DAILY	HEIGHT inch / cm	WEIGHT lbs / kg	WEIGHT CHANGE IN LAST YEAR GAIN LOSS	REASON FOR WEIGHT CHANGE
			00								
APPLICANT			01								
CO-APPLICANT			02								
DEPENDANT			02								
DEPENDANT			02								
DEPENDANT			02								

If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

Part D • Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, $ ________________ , using my/our:

Option #1 ❑ Credit Card Account

Option #2 ❑ Pre-Authorized Debit (PAD)

IMPORTANT: Initial payment will be taken on the **day the application is approved** (not the effective date). Future payments will be taken on or about the first of each month.

Subsequent Payments will be made by:

Option #1 ❑ Credit Card Account

Credit Card Billing Frequency: ❑ Monthly ❑ Semi-Annually ❑ Annually

Please note: Billing frequency discounts are not available for credit card payment options.
Please complete Part E.

Option #2 ❑ Pre-Authorized Debit (PAD)

PAD Billing Frequency: ❑ Monthly ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

Important: For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part E.

Option #3 ❑ Direct Billing (Excludes initial 2 months' payment)

Direct Billing Frequency: ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

The Professional Retiree Health & Dental Plan

***All applicants must complete Parts A, B, C, D and E**
***All applicants must complete and sign the Declaration and Authorization section.**

Part E • Payment Information and Authorization

❑ Option 1: *Credit Card Payment Information & Payment Authorization*

I/We hereby authorize Manulife to make a withdrawal from my/our account **on or about the first business day of each month** in which insurance premiums are due. This Authorization may be terminated by either Manulife or by me/us through written notice. Manulife may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Credit Card: ❑ Visa ❑ MasterCard ❑ American Express

Card Number ______________________________ Expiry Date ______(MM/YYYY)______

Name of Cardholder ______________________ Signature of Cardholder ______________________

Second Signature if Joint Account ______________________ Dated ______(DD/MM/YYYY)______

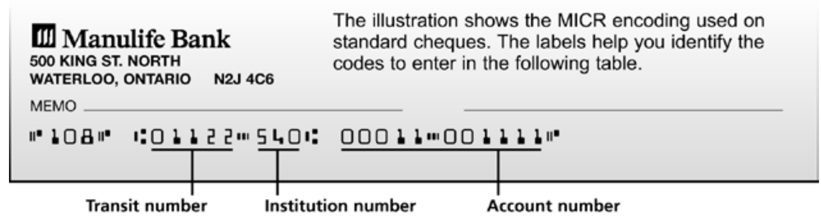
❑ Option 2: *Pre-Authorized Debit (PAD) Payment Information & Payment Authorization*

Please use the following banking information:

❑ From the cheque used to make the first payment

OR

❑ As follows: (only complete the table below if you do not have a void cheque)



Transit Number ____________ Institution Number ____________ Bank Account Number ______________________

Financial Institution ______________________ Address ______________________

Joint Accounts: Is this a joint account requiring only one signature? ❑ Yes ❑ No

If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

Signature of Account Holder ______________________ Dated ______(DD/MM/YYYY)______

Signature of Joint Account Holder ______________________ Dated ______(DD/MM/YYYY)______

Account Holder Address (if different from Applicant) ______________________

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. 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/We or Manulife may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-598-2273, or am_service@manulife.com or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

The Professional Retiree Health & Dental Plan

Please complete PARTS F & G if applying for:
• The Comprehensive Plan or
• The Bridge Plan (if it has been more than 60 days since you have been covered by a group plan or you have never been covered by a group plan).

Part F • Treating Qualified Health Care Practitioner

Primary Health Care Provider*	For Applicant	For Co-Applicant	For Dependant(s)
Name of Primary Health Care Provider			
Telephone number of Primary Health Care Provider			
Date of last consultation			
Reason for last consultation			
Diagnosis made			
Treatment given			

* Present Physician or Qualified Health Care Practitioner who holds the majority of your medical records. If none, print "none."
** If additional space is needed to respond, use a separate sheet, signed and dated.

Name and telephone number **of any other** Qualified Health Care Practitioner consulted or referred to:______________________________

____

Date and reason for consultation: ______________________________

To which individual applying for coverage does this apply? ______________________________

Part G • Medical Declaration

1. Have you, your co-applicant or any listed dependant(s) ever consulted a Physician or Qualified Health Care Practitioner about, been treated for or had any known indication of: (✔ "Yes" or "No" to all questions)

a) High blood pressure, high cholesterol or any circulatory or blood disorder ❑ Yes ❑ No

b) Heart or blood vessel disorder, heart murmur, chest pain, angina, stroke or transient ischemic attack (TIA) ❑ Yes ❑ No

c) Back, neck, disc, hip or knee pain or disorder, fibromyalgia, osteoporosis, osteopenia, chronic pain, paralysis, weakness or numbness, or any other musculoskeletal disorder ❑ Yes ❑ No

d) Digestive system disorder, Crohn's disease, ulcerative colitis, liver disease or disorder including hepatitis or hepatitis carrier state ❑ Yes ❑ No

e) Mental, nervous, emotional or neurological disorder including depression, anxiety, attention deficit disorder or stress ❑ Yes ❑ No

f) Alcohol or drug abuse, or any addiction ❑ Yes ❑ No

g) Allergies, asthma, bronchitis, respiratory disorder, shortness of breath or sleep apnea ❑ Yes ❑ No

h) Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) ❑ Yes ❑ No

i) Arthritis, rheumatism or rheumatoid arthritis ❑ Yes ❑ No

j) Cancer, Tumour, Cyst, Polyp Or Any Growth ❑ Yes ❑ No

k) Skin disorder ❑ Yes ❑ No

l) Breast disorder, menopause, reproductive disorder, infertility or assisted conception ❑ Yes ❑ No

m) Bladder, kidney or prostate disorder or other genitourinary disorder ❑ Yes ❑ No

n) Headaches or migraines ❑ Yes ❑ No

o) Diabetes, endocrine disorder, pituitary or thyroid disorder or lupus ❑ Yes ❑ No

p) Eye or ear disorder ❑ Yes ❑ No

q) Any other complaint, condition, disease or disorder ❑ Yes ❑ No

Please specify:

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Continued on page 5

The Professional Retiree Health & Dental Plan

Please complete PARTS F & G if applying for:
- **The Comprehensive Plan or**
- **The Bridge Plan** (if it has been more than 60 days since you have been covered by a group plan or you have never been covered by a group plan).

Part G • Medical Declaration (continued)

2. Have you, your co-applicant or any listed dependant(s) ever been treated for, hospitalized for or had any known physical impairments, congenital abnormality, medical condition, injury, disease or disorder **not stated above**? ❑ Yes ❑ No

3. Have you, your co-applicant or any listed dependant(s) ever been advised to have an investigation, hospitalization or surgery which has **not been completed**, or are awaiting any tests or test results? ❑ Yes ❑ No

4. Have you, your co-applicant or any listed dependant(s) ever been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years? ❑ Yes ❑ No

5. If any "Yes" answers to questions 1 to 4 of Part G, please give explanation below:

Question No.	Name of Individual	Illness/Condition/Diagnosis	Date Diagnosed	Duration	Name and Address of Qualified Health Care Practitioner and/or Hospital Providing Treatment	Current Status of Condition

6. Are you, your co-applicant or any listed dependant(s) currently using or expecting to use in the next 3 months or have you discontinued use in the last 3 months of any drug, medication, serum or other treatment? ❑ Yes ❑ No
   If "Yes," provide details below:

Name of Individual	Name of the Drug/Medication/Serum/Treatment	Condition Being Treated	Strength and Daily Dosage of the Drug/Medication/Serum	Length of Time on This Drug/ Medication/Serum/Treatment

7. Are you, your co-applicant or any listed dependant(s) pregnant? ❑ Yes ❑ No
   If "Yes," name of pregnant individual ______________________ Due date (DD/MM/YYYY) ____________

PLEASE NOTE: Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium.

Coverage will commence no earlier than the first of the month following final approval of this application. Additional medical information may be required to underwrite your application.

If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn. 500-4-A, Waterloo, ON N2J 4C6.

DECLARATION AND AUTHORIZATION

I/We, the applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I/We (the undersigned) declare that the statements contained in this application, including the Underwriting Questionnaire originally attached hereto, are true and complete. I/We understand that the application, together with any other forms signed by me/us in connection with this application, forms the basis for any certificate issued hereunder. I/We understand that any material misrepresentation shall render the insurance voidable at the instance of the Insurer. I/We have read and understand the exclusions and limitations that apply to the coverage applied for. The effective date of coverage for Health & Dental is the first of the month following the date of approval. I/We understand that any health information must be accurate as at the date the application is signed.

This plan is underwritten by The Manufacturers Life Insurance Company.

Relative to the insurance applied for, I/we, the undersigned person(s) to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me/us or my/our health or the health of any person to be insured under this plan to provide to Manulife or its reinsurers any such information for the purpose of this application and coverage and any subsequent claim. I/We authorize Manulife to consult its existing files for this purpose. I/We authorize Manulife, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me/us their products or services. I/We understand that my consent to the use of such information to offer me/us products or services is optional, and that if I/we wish to discontinue such use I/we may call or write to Manulife at the address or telephone number shown on this document.

I/We declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. I/We understand that this consent may be revoked at any time and that if as a result of such revocation the Insurer is unable to obtain proof of claim, this may result in claims not being paid. I/We acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality (see brochure or refer to Legal Info and Your Privacy on www.manulife.com/engineerscanada).

A photocopy of this signed authorization shall be as valid as the original.

Signed at (City, Province)	Signature of Primary Applicant	(DD/MM/YYYY) Dated
Signed at (City, Province)	Signature of Co-Applicant	(DD/MM/YYYY) Dated

Advisor's Report • For Advisor/Agent Use Only

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent;
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last)	Advisor code	Signature
		✖

Please send the completed application to:

Regular Mail:
Manulife
P.O. Box 670
Stn Waterloo
Waterloo, ON N2J 4B8

Courier:
Manulife
500 King Street
Affinity Markets New Business
Delivery Station 500-GB
Waterloo, ON N2J 4C6

Fax:
1-888-264-2243

Note: if you are contracted through a MGA/National Account firm, please forward the completed application to their office.

The Professional Retiree Health & Dental Plan is offered through
The Manufacturers Life Insurance Company (Manulife).

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