Medical Questionnaire – Page 4

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 approval of this application.

All applicants must complete and sign Applicant's Declaration below.

Section D • Medical Declaration

Additional medical information may be required to underwrite your application.

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: Check (✓) Yes or No to all questions.

a)	High Blood Pressure, Stroke, T.I.A. or Chest Pain	❑ Yes ❑ No	i)	Arthritis/Rheumatism	❑ Yes ❑ No
b)	Heart, High Cholesterol or Circulatory Disorder, Dizziness, Fainting or Blood Disorder	❑ Yes ❑ No	j)	Cancer, Tumour or any Growth	❑ Yes ❑ No
c)	Back, Joint or any Musculoskeletal Pain or Disorder	❑ Yes ❑ No	k)	Skin Disorder	❑ Yes ❑ No
d)	Digestive System Disorder, Liver Disease or Disorder including Hepatitis	❑ Yes ❑ No	l)	Infertility/Reproductive Disorder/ Menopause	❑ Yes ❑ No
e)	Nervous, Mental, Emotional or Stress Disorder	❑ Yes ❑ No	m)	Bladder/Kidney Disorder or other Genitourinary Disorder	❑ Yes ❑ No
f)	Alcohol/Drug Abuse	❑ Yes ❑ No	n)	Headaches/Migraines	❑ Yes ❑ No
g)	Asthma/Allergies/Respiratory Disorder or Shortness of Breath	❑ Yes ❑ No	o)	Diabetes/Endocrine Disorder	❑ Yes ❑ No
h)	Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV)	❑ Yes ❑ No	p)	Eye or Ear Disorder	❑ Yes ❑ No
			q)	Other Condition/Disease/Disorder	❑ Yes ❑ No

Please specify: _____

2. Have you, your Co-Applicant or any listed dependant(s) ever been treated or hospitalized for any Physical Impairment, Congenital Abnormality, Medical Condition, Disease or Disorder **not stated above?** Applicant ❑ Yes ❑ No Co-Applicant ❑ Yes ❑ No Dependent Child ❑ 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?** Applicant ❑ Yes ❑ No Co-Applicant ❑ Yes ❑ No Dependent Child ❑ Yes ❑ No
4. If you answered "Yes" to question 1, 2 and/or 3, please provide explanation below:

Question No.	Name of individual	Name of Illness/ Condition/Diagnosis	Date diagnosed	Duration	Name & Address of Qualified Health Care Practitioner and/or hospital providing treatment	Current status of condition

5. Are you, your Co-Applicant or any listed dependant(s) currently using or expect to use in the next 3 months any drug, medication, serum or other treatment? ❑ Yes ❑ No (✓ Yes or No) If yes, provide details below:

Name of individual	Name of the drug/ medication/serum/treatment	Condition being treated	Strength & daily dosage of the Drug/Medication/serum	Monthly cost	Length of time on this drug/medication/serum/treatment

6. Are you, your Co-Applicant or any listed dependant(s) pregnant? ❑ Yes ❑ No
   If yes, Name _____ Due Date _____ (DD/MM/YYYY)

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:

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

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

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

Applicant's Declaration • All Applicants Must Complete This Section

This plan is underwritten by The Manufacturers Life Insurance Company.

❑ Check here if you do not wish to receive further information and material on Manulife Financial's products.

I/We hereby acknowledge that the statements contained herein are true and complete, and together with any other forms signed by me/us in connection with this application, form the basis for any policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application, may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. Manulife Financial reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with Manulife Financial's Notice on Privacy and Confidentiality. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

Signed at	Signature of Applicant	Signature of Co-Applicant	Dated (DD/MM/YYYY)

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 Financial 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 Financial 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 Financial at the address shown below. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Station A, Toronto, Ontario M5W 5M3.

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Manulife Financial

HEALTH & DENTAL PLAN APPLICATION

All applicants must complete Parts A, B and C.
All applicants must complete and sign Applicant's Declaration on back page.

Advisor ID: _____

Advisor Name: _____
Advisor E-mail: _____

Part A • General Information

Applicant's Last Name _____ First Name _____ Initial _____ Government Health Card Number |_|_|_|_|_|_|_|_|_|_|

Apt. Number _____ Street Number and Name _____ Home Telephone ( ) _____

City or Town _____ Province _____ Postal Code _____

Occupation _____

Applicant:
Office Telephone ( ) _____
E-mail _____

Co-Applicant:
Office Telephone ( ) _____
E-mail _____

If additional information is required during regular business hours, how may we contact you? ❑ Home ❑ Office ❑ E-mail

Are you now covered or did you have previous group coverage with Manulife Financial or any other insurance company? ❑ Yes ❑ No
If "Yes", please indicate:

Plan Number _____ ID Number _____ Insurance Company _____ Date Benefits ended _____ (DD/MM/YYYY)

Is this application intended to replace your current coverage? ❑ Yes ❑ No
Was your previous coverage Employer Group Coverage? ❑ Yes ❑ No

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Primary Applicant's Beneficiary

Last Name _____ First Name _____

Relationship to Primary Applicant _____

Co-Applicant's Beneficiary

Last Name _____ First Name _____

Relationship to Co-Applicant _____

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed, except in Quebec where benefits will be paid directly to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee: Last Name _____ First Name _____

Relationship to Primary Applicant _____

Trustee: Last Name _____ First Name _____

Relationship to Co-Applicant _____

For Quebec residents only:

In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

❑ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

❑ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Part B • Plan Choice

I/We apply for the following Health Plan:

- ❑ Base Health and Dental Plan*
- ❑ Bronze Health and Dental Plan
- ❑ Silver Health and Dental Plan
- ❑ Gold Health and Dental Plan
- ❑ Base Dental Plan*
- ❑ Bronze Dental Plan*
- ❑ Silver Dental Plan*
- ❑ Gold Dental Plan*

*These plans do not require completion of the Medical Questionnaire of this application.

Health Plan Application – Page 2

All applicants must complete Parts A, B and C.
All applicants must complete and sign Page 4, Applicant's Declaration.

Part C • Billing Options

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

Option #1 ❑ Financial Services Account (Pre-Authorized Debit)
Option #2 ❑ Credit Card Account

Subsequent Payments will be made by:

Option #1 ❑ Pre-Authorized Debit (PAD) from my/our Financial Services Account
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 D.

Option #2 ❑ 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 D.

Option #3 ❑ Direct Billing
Direct Billing Frequency: ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

Part D • Payment Information and Authorization

PAYMENT INFORMATION

For Pre-Authorized Debit (PAD) payment options

Name of Account Holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Transit Number _____

Type of Account: ❑ Personal Chequing ❑ Chequing/Savings ❑ Savings ❑ Current ❑ Direct Deposit Account ❑ Other

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.

For Credit Card payment options

Credit Card: ❑ Visa ❑ MasterCard ❑ American Express

Account Number _____ Expiry Date _____ (MM/YYYY)

Name of Cardholder _____ Signature of Cardholder _____

PAYMENT AUTHORIZATION

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife Financial 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 Financial may attempt to withdraw that payment again within 30 days. Manulife Financial 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 Financial 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 Financial 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 1-800-268-3763, more_info@manulife.com or write to us at Manulife Financial, 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.

Signature of Account Holder _____ Dated _____ (DD/MM/YYYY)

Second Signature If Joint Account _____ Dated _____ (DD/MM/YYYY)

Account Holder Address (if different from Applicant) _____

For Credit Card payment options

I/We hereby authorize Manulife Financial 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 Financial or by me/us through written notice.

Manulife Financial 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.

Signature of Cardholder _____ Dated _____ (DD/MM/YYYY)

Second Signature If Joint Account _____ Dated _____ (DD/MM/YYYY)

Medical Questionnaire – Page 3

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 approval of this application.

All applicants must complete and sign Page 4, Applicant's Declaration.

If applying for the Bronze, Silver or Gold Health & Dental Plan, you must complete Sections A, B and C and complete/sign the Applicant's Declaration. Section D must be completed if any questions in Section C are answered "yes". If applying for Base Health & Dental, Base Dental, Bronze Dental, Silver Dental or Gold Dental Plan, applicants must complete Section A and complete/sign the Applicant's Declaration.

Section A • Individuals To Be Covered

FIRST NAME / LAST NAME	HEALTH CARD NUMBER	CODE	SEX	BIRTH DATE (DD MM YYYY)	AGE	SMOKER? NO. OF CIGARETTES DAILY	HEIGHT (cm/inch)	WEIGHT (kg/lb)	WEIGHT CHANGE IN LAST YEAR (GAIN / LOSS)	REASON FOR WEIGHT CHANGE
		00								
APPLICANT		01								
CO-APPLICANT		02								
DEPENDENT CHILD		02								
DEPENDENT CHILD		02								
DEPENDENT CHILD										
DEPENDENT CHILD										

Section B • Treating Qualified Health Care Practitioner

Must be completed for Bronze Health & Dental, Silver Health & Dental, or Gold Health & Dental Plan.

Name and address of Present Primary Health Care Provider / Physician (who holds the majority of your medical records) and any other Qualified Health Care Practitioners consulted (if none, print "none"):

Primary Health Care Provider	For the Applicant	For the Co-Applicant	For all Dependant(s)
Name of Primary Health Care Provider:			
Address of Primary Health Care Provider:			
Last Consultation - Date:			
- Reason:			
- Diagnosis made:			
- Treatment given:			

Name and address of any other Qualified Health Care Practitioner consulted: _____

_____

_____

Name of person who consulted other Practitioner: _____

Date and reason for consultation: _____

_____

Note: Additional medical information may be required to underwrite your application.

Section C • Simplified Questionnaire

Must be completed for Bronze Health & Dental, Silver Health & Dental, or Gold Health & Dental Plan.

Note: Additional medical information may be required to underwrite your application.

Have you, your Co-Applicant or any listed dependant:

1. Been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years? ❑ Yes ❑ No
2. Consulted or been advised to consult a Qualified Health Care Practitioner about or had any known indication of a medical condition within the last year? ❑ Yes ❑ No
3. Sustained any injury or been treated for any medical condition that requires or has required the services of a Qualified Health Care Practitioner at least once per year within the last 2 years? ❑ Yes ❑ No
4. a) Been advised to use a medication or treatment for a chronic and/or recurring medical condition? ❑ Yes ❑ No

   b) Used any medication or treatment for 20 or more days within the past year? ❑ Yes ❑ No

   c) Expect to use any medication or treatment within the next 3 months? ❑ Yes ❑ No

   Note: Medications used for birth control or to treat minor ailments like cold or flu are not to be considered "yes" when answering this question.
5. Been diagnosed with any medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? Do not include minor ailments like the cold and flu. ❑ Yes ❑ No

If any questions above are answered "Yes," please complete Section D on Page 4.

Quebec residents may detach and mail the Medical Questionnaire portion to the insurer.
This application is not valid unless a properly completed Medical Questionnaire is received by Manulife Financial.