

CARP Guaranteed Issue Life Insurance Application Form

The Manufacturers Life Insurance Company

00622 001
00622 002

WOEXO

CARP MEMBER INFORMATION (Please print)

Last Name _____ First Name _____

Home Address _____ Unit/Apt. # _____

City _____ Province _____ Postal Code _____ Phone Number _____

Birth Date _____ Male Female Smoker Non-Smoker*
(DD/MM/YYYY)

*Non-Smoker rates apply to people who have not used tobacco, tobacco cessation products or marijuana in the last 12 months and who meet Manulife's health standards.

Beneficiary:

Last Name _____ First Name _____

Relationship to Member _____

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed. By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the Trustee to hold in trust for the child until the child comes of age.

Trustee:

Last Name _____ First Name _____

Relationship to Beneficiary _____

SPOUSE INFORMATION (Complete if spouse is applying for coverage)

Last Name _____ First Name _____

Birth Date _____ Male Female Smoker Non-Smoker*
(DD/MM/YYYY)

*Non-Smoker rates apply to people who have not used tobacco, tobacco cessation products or marijuana in the last 12 months and who meet Manulife's health standards.

Beneficiary:

Last Name _____ First Name _____

Relationship to Spouse _____

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed. By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the Trustee to hold in trust for the child until the child comes of age.

Trustee:

Last Name _____ First Name _____

Relationship to Beneficiary _____

CHOOSE YOUR BENEFIT AMOUNT (Refer to the rates in the brochure to determine your premium)

If you intend to replace coverage (other than coverage you may have through an employer group benefits plan), 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.

CARP MEMBER COVERAGE

Monthly Premium: \$ _____

- 1 Unit (\$2,500)
- 2 Units (\$5,000)
- 3 Units (\$7,500)
- 4 Units (\$10,000)
- 5 Units (\$12,500)
- 6 Units (\$15,000)
- 7 Units (\$17,500)
- 8 Units (\$20,000)
- 9 Units (\$22,500)
- 10 Units (\$25,000)

SPOUSE COVERAGE

Monthly Premium: \$ _____

- 1 Unit (\$2,500)
- 2 Units (\$5,000)
- 3 Units (\$7,500)
- 4 Units (\$10,000)
- 5 Units (\$12,500)
- 6 Units (\$15,000)
- 7 Units (\$17,500)
- 8 Units (\$20,000)
- 9 Units (\$22,500)
- 10 Units (\$25,000)

CHOOSE YOUR PAYMENT METHOD

Monthly by Pre-Authorized Debit (PAD) from my Financial Institution Account.

Important: For verification purposes, please enclose a sample cheque marked "VOID".

Credit Card Visa MasterCard Billing Frequency: Monthly Annually

Credit Card # _____ Expiry Date _____ (MM/YYYY)

Cardholder _____ Signature of Cardholder _____
(if other than Member or Spouse)

PAYMENT INFORMATION AND AUTHORIZATION

PAYMENT INFORMATION

For Pre-Authorized Debit (PAD) Payment Options

Name of Account Holder _____

Financial Institution _____ Address _____

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.

PAYMENT AUTHORIZATION

For Pre-Authorized Debit (PAD) Payment Options

I/We authorize Manulife to withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date I/we sign this authorization. I/We understand that except for the initial premium, which is due with this application, subsequent premiums will be withdrawn on the first business day of the month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with the insurance contract and as required to administer the policy; **I/we waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If my/our 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 me/us for an alternate method of payment if my/our 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. Premium amounts may change in accordance with my/our insurance contract. I/We and/or Manulife can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a 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 1-800-396-4389, e-mail us at am_info@manulife.com or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

PAYMENT INFORMATION AND AUTHORIZATION (Continued)

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, you may contact your financial institution or visit www.cdnpay.ca.

Name of Account Holder _____ Signature of Account Holder _____

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

Account Holder Address (if different from Member) _____

For Credit Card Payment Options

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 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.

Name of Account Holder _____ Signature of Account Holder _____

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

NOTICE ON PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested on your application form is required to process your application. To protect the confidentiality of this information, Manulife will establish a financial services file from which this information will be used to process your application(s), offer and administer services and process claims relative to the insurance applied for. Access to the 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 countries. 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 your file contains and make corrections by writing to the Privacy Officer, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6.

NOTE TO CARP MEMBERS: Your application for the Guaranteed Issue Life Insurance Plan may be made known to The McLennan Group Life Insurance Inc. in order to bring other products and services offered under the Insurance Programs for CARP Members to your attention.

AUTHORIZATION AND DECLARATION (Please read carefully before signing)

I/We hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I/We (the undersigned) declare that the statements contained in this application form are true and complete. I/We understand that the application form, together with any other forms signed by me/us in connection with this application, forms the basis for any policy issued hereunder. I/We understand that any material misrepresentation, including misstatement of smoker status, 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. Suicide within two years of the effective date is a risk not covered. I/We understand that insurance will take effect on the date the application form and payment of the first premium are received by Manulife at its office, subject to approval of the Insurer's underwriters, and that I/we am/are not eligible for insurance under more than one Guaranteed Issue Life Insurance Plan issued by Manulife. I/We hereby designate the individual(s) named as beneficiary(ies) on this application form to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate. I/We acknowledge receipt of and confirm agreement with the Notice on Privacy and Confidentiality.

Member's Signature _____ Spouse's Signature _____

Dated this _____ day of _____, 20_____ Dated this _____ day of _____, 20_____

If you need assistance, call us toll-free at 1-800-396-4389
Please mail completed application to: Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

Coverage underwritten by The Manufacturers Life Insurance Company (Manulife)