TERM LIFE INSURANCE PLAN
for CARP Members

Manulife Financial
For your future™

CARP.TL.EN (04/11)

Your Personal Information *(Please print)*

Last Name　First　☐ Male ☐ Female

Address　City　Province　Postal Code

Date of Birth DD/MM/YYYY　Country of Birth　☐ Smoker ☐ Non-Smoker[1]

E-mail　Tel. (Home)　(Bus.)

Occupation　Self-employed? ☐ Yes ☐ No　If yes, please describe the nature of your business and duties.

[1] Non-smoker rates apply to people who have not used any form of tobacco, tobacco cessation products or marijuana in the past 12 months.

Other Insurance Information

Do you currently have health coverage with Manulife Financial? ☐ Yes ☐ No If yes, please provide your Policy No. ____________

Do you have any pending or existing Life Insurance coverage with Manulife Financial or any other company? ☐ Yes ☐ No If yes, please complete the following:

Company Name	Personal or Business	Amount of Coverage	Do you intend to replace this coverage?
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

If you intend to replace coverage, do not cancel your existing coverage. Manulife Financial may not be able to issue a policy where replacement of an existing insurance product is intended.

Your Choice of Coverage

I am applying for ☐ New coverage ☐ Additional coverage. If currently insured under these plans, list Policy No. ____________

Amount of Coverage (do not include existing coverage) ☐ **$50,000** ☐ **Other $** ____________ Available from $50,000 to $150,000, in increments of $25,000.

Are you also applying for health coverage with Manulife Financial? ☐ Yes ☐ No

Financial Information *(Complete only if total term life insurance coverage — applied for and existing, all companies — exceeds $250,000).*

Annual Net Earned Income, after expenses but before tax $____________

Method of Payment

☐ **ANNUAL** ☐ **MONTHLY**

☐ **Charge to my** ☐ MasterCard ☐ Visa　Card No. ____ ____ ____ ____　Expiry Date MM YY

Name of Cardholder (if other than Member) ____________

☐ **By Pre-Authorized Debit (PAD)**
Please enclose a sample cheque marked "VOID".

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

PAYMENT AUTHORIZATION
For Credit Card payment options

I hereby authorize Manulife Financial to make a withdrawal from my 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 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.

Name of Cardholder ____________ Signature of Cardholder ____________

Second Signature If Joint Account ____________ Dated DD/MM/YYYY

For Pre-Authorized Debit (PAD) payment options

I authorize Manulife Financial to withdraw monthly premiums from my bank account for insurance premiums due on or after the date I sign this authorization. I authorize Manulife Financial to withdraw premiums on or about the first business day of each month or the next business day thereafter. Withdrawals from my account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. **I waive the right to receive further notice of the amount and date of each automatic withdrawal.** If my 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 me for an alternate method of payment if my payment is not honoured. All one-time or automatic withdrawals from my bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I and/or Manulife Financial can end this agreement at any time by giving 10 days' written notice. I understand that cancelling this PAD agreement may result in a 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 1 855 460-3631, am_service@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, you may contact your financial institution or visit www.cdnpay.ca.

To authorize all Pre-Authorized Debit (PAD) payments, please sign below.

Name of Account Holder ____________ Signature of Account Holder ____________

Second Signature If Joint Account ____________ Dated DD/MM/YYYY

Account Holder Address (if different from Applicant) ____________

Beneficiary Designation

I hereby designate the individual named as beneficiary on this application 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.

Beneficiary:

First Name	Last Name
Relationship	

If you designate a beneficiary under the age of 18, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed.

Trustee:

First Name	Last Name
Relationship	

This application is not valid unless the Underwriting Questionnaire is fully completed and the application is signed.

Underwriting Questionnaire

Physician's Name		Physician's Telephone
Physician's Address		
Date Last Seen DD/MM/YYYY	Reason Last Seen	
Tests, Treatment, Medication Prescribed (if none, state "None")		Your Height ☐ ft/in ☐ cm Your Weight ☐ lbs ☐ kg
Results and Current Status		

Have you: YES NO

1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason: ☐ ☐

2. Within the past 5 years, had your driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including nature of offence(s), date(s), driver's licence number and licensing province: ☐ ☐

3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s): ☐ ☐

4. Within the next 12 months, any intention of travelling or residing outside North America? If yes, give details including where, when, why and for how long. ☐ ☐

5. Within the past 7 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? If yes, give details including drug or alcohol type(s) and date(s) last used: ☐ ☐

6. Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned? ☐ ☐

7. Ever had any positive test, treatment for or exposure to HIV virus or AIDS? ☐ ☐

8. Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.), been advised to undergo further investigation, see another doctor or have surgery? ☐ ☐

If you answered yes to any of Questions 6, 7 and 8, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question #	Nature of Disorder	Date and Duration	Treatment and Current Status	Attending Physician or Hospital

9. a) Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer? ☐ ☐

   b) Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, retinitis pigmentosa or any hereditary disease? ☐ ☐

If yes to a) or b) above, please complete the following:

Family Member	Condition (If cancer, specify type)	Age at Onset	Age at Death and Cause (if applicable)

Declaration and Authorization *(Please read carefully before signing)*

DECLARATION: I (the Member) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I declare that the statements contained in this application, including but not limited to the Underwriting Questionnaire included herein, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any policy issued hereunder. I have read and understand that there are exclusions and limitations on the coverage applied for. I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date is a risk not covered. I understand that insurance will take effect on the date my properly completed application and the first premium are received by Manulife Financial, subject to the approval of the Company's underwriters. I understand that any health information must be accurate as at the date the application is signed.

AUTHORIZATION: Relative to the insurance applied for, I, the undersigned applicant to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB, Inc., the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency, or other organization, institution or person that has any records or knowledge of me, or of my health, to give Manulife Financial or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife Financial to consult its existing files for this purpose. I authorize Manulife Financial, its subsidiaries, affiliates and agents to use this information to offer me their products and services. I understand that my consent to the use of this information to offer me products or services is optional and that if I wish to discontinue such use, I may call 1 855 460-3631 or write to Manulife Financial at: P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3. A photocopy or faxed copy of this authorization shall be as valid as the original.

I acknowledge receipt of, and confirm my agreement with, the Notice on Exchange of Information and the Notice on Privacy and Confidentiality. I declare that I 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. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any policy or certificate issued as a result of this application. I 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.

Applicant's Signature ____________ Signed at (City/Town) ____________ Date DD/MM/YYYY ____________

Plan underwritten by The Manufacturers Life Insurance Company.

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