

Primary Applicant Information

Last Name _____ First Name _____ Initial _____

Address _____

City _____

Province _____ Postal Code _____

Date of Birth: DD / MM / YYYY Male Female

Telephone (Res.) (_____) _____

Telephone (Bus.) (_____) _____

Please provide information about your current or recently ended group life plan:

Employer Name _____ Insurance Company _____

Life Benefit Amount _____ Date Benefits End(ed) _____

Group and Identification Numbers _____

Spouse Information (if applying for coverage)

Last Name _____ First Name _____ Initial _____

Address _____

City _____

Province _____ Postal Code _____

Date of Birth: DD / MM / YYYY Male Female

Telephone (Res.) (_____) _____

Telephone (Bus.) (_____) _____

Please provide information about your coverage under the primary applicant's current or recently ended group life plan:

Employer Name _____ Insurance Company _____

Life Benefit Amount _____ Date Benefits End(ed) _____

Group and Identification Numbers _____

Choice of Coverage

I apply for FollowMe™ Life coverage:

Amount of coverage \$ _____

(Available from \$25,000 to \$200,000; you are eligible to apply for FollowMe Life coverage equal to or less than your group life coverage amount.)

Smoker Non-Smoker*

*Non-smoker rates apply to people who have not used tobacco or marijuana in any form, including smoking cessation products, in the last 12 months.

Choice of Coverage

I apply for FollowMe™ Life coverage:

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Smoker Non-Smoker*

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Beneficiary Information

Beneficiary on Primary Applicant's Coverage

I hereby designate the individual(s) named as beneficiary below to receive any death benefit payable with respect to the coverage applied for.

Beneficiary(ies):

1. Last Name _____ First Name _____

Relationship to Primary Applicant _____ % of Benefit _____

2. Last Name _____ First Name _____

Relationship to Primary Applicant _____ % of Benefit _____

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 _____

Beneficiary Information

Beneficiary on Spouse's Coverage

I hereby designate the individual(s) named as beneficiary below to receive any death benefit payable with respect to the coverage applied for.

Beneficiary(ies):

1. Last Name _____ First Name _____

Relationship to Spouse _____ % of Benefit _____

2. Last Name _____ First Name _____

Relationship to Spouse _____ % of Benefit _____

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 Spouse _____

Payment Options

PAYMENTS will be made by: Option #1 Pre-Authorized Monthly Debit (PAD) plan from my Financial Services Account
Important: Please enclose a sample cheque marked "VOID".

Option #2 Credit Card

Credit Card: Visa MasterCard American Express

Billing Frequency: Monthly Annually

Credit Card No. _____ Expiry Date MM / YYYY

Name of Cardholder _____ Signature of Cardholder _____

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.

Payment Authorization

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife Financial to withdraw monthly premiums from my bank account for insurance premiums due on or after the date I/we sign this authorization. I/We 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/our account may be for variable amounts and 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. If my/our 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/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. I/We and/or Manulife Financial 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 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 1-800-396-4389, 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.

Name of Account Holder _____ Signature of Account Holder _____

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.

Name of Cardholder _____ Signature of Cardholder _____

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

Declaration – Please read carefully before signing.

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

I/We, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/We declare that the statements contained in this application 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 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/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that insurance will take effect on the date the application and payment of the first premium are received by Manulife Financial at its office.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death.

I/We acknowledge receipt of, and agree with, the Notice on Privacy and Confidentiality as stated within the brochure.

By signing this application, each applicant declares that he/she is not currently ill or injured or, where the Primary Applicant's group life plan has already ended, was not ill or injured at the time the Plan ended.

Important: This product is not intended as replacement insurance for any life insurance you may have. Please do not cancel your existing coverage.

Signed at: _____ Date: _____ DD / MM / YYYY Applicant's Signature _____

Signed at: _____ Date: _____ DD / MM / YYYY Spouse's Signature _____
(if spouse is applying for coverage)

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