CARP Health & Dental Insurance Plan Application

ALL APPLICANTS MUST COMPLETE PARTS A, B, C, D and E OF THE APPLICATION FORM.
ALL APPLICANTS MUST SIGN AND COMPLETE "APPLICANT'S DECLARATION".

Agent I.D. **03496**

For Manulife Financial Use Only.
Keyed ______
Approval ______

PART A • GENERAL INFORMATION

GOVERNMENT HEALTH CARD NUMBER

Applicant's Last Name ______ First Name ______ Initial ______

Apt. Number ______ Street # and Name ______ City or Town ______

Province ______ Postal Code ______ Home Telephone (______) ______

Occupation ______ Marital Status ❑ Single ❑ Married ❑ Other ______

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

Applicant's Fax (______) ______ Co-Applicant's Fax (______) ______

Applicant's E-mail ______ Co-Applicant's E-mail ______

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

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

Plan Number ______ ID Number ______ Insurance Company ______ Date Benefits Ended ______

Plan Number ______ ID Number ______ Insurance Company ______ Date Benefits Ended ______

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 prior coverage Employer Group Coverage? ❑ Yes ❑ No

PART B • INDIVIDUALS TO BE COVERED

HEALTH CARD NUMBER

APPLICANT LAST NAME ______ FIRST NAME ______

CODE	SEX	BIRTHDATE DD	MM	YYYY	AGE	SMOKER? # CIGARETTES/DAY	HEIGHT IN/CM	WEIGHT LBS/KG	WEIGHT CHANGE IN LAST YEAR GAIN	LOSS	REASON FOR WEIGHT CHANGE
00											

HEALTH CARD NUMBER

CO-APPLICANT LAST NAME ______ FIRST NAME ______

CODE	SEX	BIRTHDATE DD	MM	YYYY	AGE	SMOKER? # CIGARETTES/DAY	HEIGHT IN/CM	WEIGHT LBS/KG	WEIGHT CHANGE IN LAST YEAR GAIN	LOSS	REASON FOR WEIGHT CHANGE
01											

HEALTH CARD NUMBER

DEPENDANT LAST NAME ______ FIRST NAME ______

CODE	SEX	BIRTHDATE DD	MM	YYYY	AGE	SMOKER? # CIGARETTES/DAY	HEIGHT IN/CM	WEIGHT LBS/KG	WEIGHT CHANGE IN LAST YEAR GAIN	LOSS	REASON FOR WEIGHT CHANGE
02											

HEALTH CARD NUMBER

DEPENDANT LAST NAME ______ FIRST NAME ______

CODE	SEX	BIRTHDATE DD	MM	YYYY	AGE	SMOKER? # CIGARETTES/DAY	HEIGHT IN/CM	WEIGHT LBS/KG	WEIGHT CHANGE IN LAST YEAR GAIN	LOSS	REASON FOR WEIGHT CHANGE
02											

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

PART C • PLAN CHOICE

I/WE apply for the following plan: ❑ EXTENDED HEALTH CARE* ❑ DENTAL ENHANCED* ❑ THREE STAR* ❑ FOUR STAR ❑ FIVE STAR

No medical questionnaire required for these plans.

PART D • PAYMENT OPTIONS

INITIAL PAYMENT: I/We hereby authorize Manulife Financial to debit the initial 2 months' premium from my/our:

❑ Financial Institution Account ❑ Credit Card Account

SUBSEQUENT PAYMENTS: Will be made by:

❑ **Pre-Authorized Debit (PAD)** from my Financial Institution Account *(Please also complete PART E below)*

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

❑ **Credit Card** *(Please read and sign PART E below):* Billing Frequency: ❑ Monthly ❑ Semi-annually ❑ Annually

❑ Visa ❑ MasterCard ❑ American Express Account No. ______________________ Expiry Date ____________ (MM/YYYY)

Cardholder ______________________ (if other than Applicant or Co-Applicant) Signature of Cardholder ______________________

❑ **Direct Billing:**

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

Important: For verification purposes we require a VOID cheque if payment is being withdrawn from your financial institution account.

Please Note: Billing frequency discounts are not available for Credit Card payment options.

PART E • PAYMENT INFORMATION and AUTHORIZATION

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 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 1-877-551-5566, by e-mail at 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, 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)

Medical Questionnaire

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 on the first of the month following approval of the application.

If applying for the Extended Health Care Plan, Dental Enhanced Plan or Three Star Plan, you DO NOT need to complete Sections A, B or C. If applying for the Four Star or Five Star Plan, you must complete Sections A and B and the Applicant's Declaration. Section C must be completed if any questions in Section B are answered "yes." All applicants must complete the Applicant's Declaration.

SECTION A • TREATING QUALIFIED HEALTH CARE PRACTITIONER

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 B • SIMPLIFIED QUESTIONNAIRE

Must be completed in full if you are selecting the Four Star or Five Star 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 cold or flu. ❑ Yes ❑ No

If any questions above are answered "Yes," please complete Section C on next page.

Medical Questionnaire - Continued

SECTION C • MEDICAL DECLARATION

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

____

____

2. Have you, your Co-Applicant or any listed dependant ever been treated for, hospitalized for or had 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 questions 1, 2 and/or 3, please provide explanation below:

Question No.	Name of Individual	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 expecting to use in the next 3 months, any drug, medication, serum or other treatment? ❑ Yes ❑ No If "Yes", provide details below:

Name of Individual	Name of Drug/Serum/ Medication/Treatment	Condition Being Treated	Strength & Daily Dosage of the Drug/Serum/Medication	Monthly Cost	Length of Time on this Drug/ Serum/Medication/Treatment

6. Are you, your Co-Applicant, or any listed dependant(s) pregnant? ❑ Yes ❑ No

If "yes," Name ____________________ Date Due ____________________
(DD/MM/YYYY)

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.

DECLARATION: 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 have read and agreed with the Notice on Privacy and Confidentiality as stated on this application. 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.

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 Financial 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 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 countries. Your participation in the CARP Guaranteed Issue Life Insurance Plan may be made known to The McLennan Group in order to bring other products and services offered under the CARP Insurance Programs to your attention. You may request to review the personal information your file contains and make corrections by writing to the Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3.

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

For your future™

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