



## 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           | <input type="checkbox"/> ft/in <input type="checkbox"/> cm |
|   |            | Your Weight           | <input type="checkbox"/> lbs <input type="checkbox"/> kg   |
| Results and Current Status                                      |            |                       |  |

**Have you:** YES NO

- Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:  YES  NO

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- 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:  YES  NO

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- 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):  YES  NO

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- 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.  YES  NO

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- 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:  YES  NO

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- 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?  YES  NO
- Ever had any positive test, treatment for or exposure to HIV virus or AIDS?  YES  NO
- 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?  YES  NO

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 |
|------------|--------------------|-------------------|------------------------------|---------------------------------|
|            |                    |                   |                              |                                 |
|            |                    |                   |                              |                                 |

- Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?  YES  NO
- 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?  YES  NO

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.

DD/MM/YYYY

Applicant's Signature

Signed at (City/Town)

Date

## Plan underwritten by The Manufacturers Life Insurance Company.

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