Manulife Financial

HEALTH & DENTAL PLAN APPLICATION

***All applicants must complete parts A, B, C and D**

***All applicants must complete and sign Applicant's Declaration on back page.**

WSE

For Manulife Financial Use Only.
Keyed _____
Approval _____

Agent ID
04402

Logo ID

Part A • General Information

Applicant's Last Name _____ First Name _____ Initial _____ Application Number _____

Apt. Number _____ Street Number and Name _____ Home Telephone ( ) _____

City or Town _____ Province _____ Postal Code_____ Occupation _____

Applicant:

Office Telephone ( ) _____

Fax ( ) _____

Email _____

Co-Applicant:

Office Telephone ( ) _____

Fax ( ) _____

Email _____

If additional information is required during regular business hours, how may we contact you? ❑ Home ❑ Office ❑ Email

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

Plan Number _____ ID Number _____ Insurance Company _____ Date Benefits ended _____ (DD/MM/YYYY)

Plan Number _____ ID Number _____ Insurance Company _____ Date Benefits ended _____ (DD/MM/YYYY)

Is this application intended to replace your current coverage? ❑ Yes ❑ No

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Applicant's Beneficiary: _____ Co-Applicant's Beneficiary: _____

Relationship to Applicant _____ Relationship to Co-Applicant _____

If you designate a beneficiary under the age of 18, benefits will be paid to the tutor or administrator, as the case may be.

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is revocable.)

❑ I hereby declare and stipulate that the beneficiary designations made in this form are revocable.

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Signature of Applicant _____ Signature of Co-Applicant _____

Date _____ (DD/MM/YYYY) Date _____ (DD/MM/YYYY)

Part B • Plan Choice

I/We apply for the following Health Plan:

❑ Base Health and Dental Plan*
❑ Bronze Health and Dental Plan
❑ Silver Health and Dental Plan
❑ Gold Health and Dental Plan

❑ Base Dental Plan*
❑ Bronze Dental Plan*
❑ Silver Dental Plan*
❑ Gold Dental Plan*

* These plans do not require completion of the Medical Questionnaire of this application.

***All applicants must complete parts A, B, C and D**
***All applicants must complete and sign Page 4, Applicant's Declaration**

Part C • Billing Options

Initial Payment: I hereby authorize Manulife Financial to debit the initial 2 months premium, $_____ , from my:
❑ Financial Institution Account ❑ Credit Card Account

Subsequent Payments: Will be made by:
❑ Pre-Authorized Collection Plan (PAC) From My Financial Institution Account (Please also complete PART D below)
PAC Billing Frequency: ❑ Monthly ❑ Semi-annually (2% Discount) ❑ Annually (4% Discount)
❑ Credit Card (Please read and sign PART D below): ❑ Visa ❑ MasterCard ❑ Amex Account # _____ Expiry Date _____
(MM / YY)
Cardholder _____ Signature of Cardholder _____
(if other than Applicant or Co-Applicant)

Credit Card Billing Frequency: ❑ Monthly ❑ Semi-annually ❑ Annually
❑ Direct Billing: Billing Frequency: ❑ Semi-annually (2% Discount) ❑ Annually (4% Discount)

Important: For verification purposes we require a VOID cheque if a payment is being withdrawn from your Financial Institution Account.
Please Note: Billing frequency discounts are not available for Credit Card payment options.

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 NSF fee will be charged for all NSF transactions.

Part D • Financial Institution

Name of account holder(s) if different from Applicant _____

Financial Institution _____

Address _____ City/Town _____

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. This authorization shall remain in effect unless prior written notice is given to Manulife Financial by the account holder requesting cancellation.

For Pre-Authorized Collection and Credit Card Billing 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.

_____ _____
Signature of account holder Second signature if joint account

Medical Questionnaire – Page 3

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 no earlier than the first of the month following approval of this application.

If applying for the Bronze, Silver or Gold Health & Dental Plan you must complete Sections A, B and C and complete/sign the Applicant's Declaration. Sections D and E must be completed if any questions in Section C are answered "yes". If applying for Base Health & Dental, Base Dental, Bronze Dental, Silver Dental or Gold Dental Plan applicants must complete Section A and complete/sign the Applicant's Declaration.

***All applicants must complete and sign Page 4, Applicant's Declaration**

Section A • Individuals to be Covered

FIRST NAME / LAST NAME	HEALTH CARD NUMBER	CODE	SEX	BIRTH DATE (DD MM YYYY)	AGE	SMOKER? NO. OF CIGARETTES DAILY	HEIGHT (cm/inch)	WEIGHT (kg/lb)	WEIGHT CHANGE IN LAST YEAR (GAIN / LOSS)	REASON
		00								
APPLICANT		01								
CO-APPLICANT		02								
DEPENDANT CHILD		02								
DEPENDANT CHILD		02								
DEPENDANT CHILD		02								
DEPENDANT CHILD										

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

Section B • Treating Qualified Health Care Practitioner

Must be completed for all plans except Base Health & Dental, Base Dental, Bronze Dental, Silver Dental and Gold Dental.

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 the 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 C • Simplified Questionnaire

Must be completed for all plans except Base Health & Dental, Base Dental, Bronze Dental, Silver Dental and Gold Dental.

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 major medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? ❑ Yes ❑ No

Note: Additional medical information may be required to underwrite your application.

If any questions above are answered "Yes", please complete sections D and E on page 4.

Medical Questionnaire – Page 4

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 no earlier than the first of the month following approval of this application.

***All applicants must complete and sign Page 4, Applicant's Declaration**

Application Number _____

Section D • Medical Conditions

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), Human Immunodeficiency Syndrome (HIV) ❑ Yes ❑ No
i) Arthritis/Rheumatism ❑ Yes ❑ No
j) Cancer, Tumor 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 ❑ Yes ❑ No

Please specify: _____

2. Have you, your Co-Applicant or any listed dependant(s) ever been treated or hospitalized for any Physical Impairment, Congenital Abnormality, Medical Condition, Disease or Disorder not stated above? Applicant ❑ Yes ❑ No Co-Applicant ❑ Yes ❑ No Dependant 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 Dependant Child ❑ Yes ❑ No
4. **If answer is "Yes" to any question in Section D, give explanation below:**

Question No.	Proposed insured with condition	Name of Illness/Condition	Date diagnosed	Duration	Name & Address of Qualified Health Care Practitioner and/or hospital providing treatment	Results of treatment & extent of recovery

Section E • Medications and Treatments

5. Are you, your Co-Applicant or any listed dependant(s) currently using or expect to use in the next 3 months any drug, medication, serum or other treatment? ❑ Yes ❑ No (✓ Yes or No) If yes, provide details below:

Proposed insured	Name of the drug/ medication/serum/treatment	Condition being treated	Strength & daily dosage of the Drug/Medication/serum	Monthly cost	Length of time on this drug/medication/serum/treatment

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

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

Note: Additional medical information may be required to underwrite your application.

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.

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 acknowledge receipt of and agree with the Notice on Privacy and Confidentiality as stated in the brochure. 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.

_____ _____ Dated _____

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

This Plan is offered through Manulife Financial (The Manufacturers Life Insurance Company).