Life Insurance Application Guide

An exclusive offer for CAO members

Thank you for your interest in Life Insurance through the Canadian Association of Optometrists (CAO). This application package has been designed to make it easy to apply for Term Life Insurance coverage, insured by Manulife Financial.

Included in this package are the plan design options, the premium rate schedule, and the application form from Manulife Financial. Coverage is sold in units of $25,000, and the rates depend on your age bracket, your gender, and your smoking status. For example, if you were looking for $300,000 of Term Life Insurance and were a 35-year-old, non- smoking male, you would be purchasing 12 units of coverage x $37.50 = $450 annually, plus 8% retail sales tax.

The Term insurance renews annually on January 1st of every year, regardless of when it was purchased. The annual premiums are subject to change at that time. Historically, the rates have remained the same for over a decade – however, Manulife does have the ability to change the premiums annually. Your premiums are based on your age on January 1st of each year; as you enter a new age bracket, you will experience an increase in premium rates.

You may also wish to consider adding a Personal Accident Insurance Rider to your Term Life Insurance product. This is optional coverage that would provide an additional sum of money, on top of the Life Insurance amount, to your beneficiary should your cause of death be accidental. If you are dismembered in an accident, a percentage of the principal sum amount is payable, according to a schedule of losses. The Personal Accident Insurance Rider is available for purchase in addition to any amount of Life Insurance units. The Rider is available in units of $25,000 up to a maximum of $250,000. If this is of interest to you, please reach out to us for more details.

Also included in this application process is a brochure from the Canadian Life & Health Insurance Association (CLHIA). It provides a comprehensive review of the many different insurance products available in the Canadian marketplace. We recommend that you review this to help you make an informed decision on your life insurance needs.

We hope you find this application guide helpful. If you have any questions at any time, please do not hesitate to send your inquiries to the following email address:

cao@hubinternational.com

As a valued CAO member, we're looking forward to working with you and providing you with enhanced insurance coverage at exclusive prices.

CANADIAN ASSOCIATION OF OPTOMETRISTS
ASSOCIATION CANADIENNE DES OPTOMÉTRISTES

LIFE – CANADIAN ASSOCIATION OF OPTOMETRISTS

Special Instructions

Manulife is responsible for the issuing of certificates and amendments.

Insurance Program Details:

Effective Date: January 1, 1993
Anniversary Date: January 1 of every year

Plans/Coverage:

For Life Coverage:
Eligibility:

Eligibility Requirements:

- Members of the Association of Optometrists working full time.
- Minimum of 30 hours/week and under age 65.
- Final Year Students and Employees of the Association of Optometrists
- Spouses are eligible provided the Member is Insured (a Spouse cannot have more coverage than the Member – Issued as a rider).

Coverage Detail:

Unit Value is $25,000 Benefit Levels:
Member: Min: 1 Unit – Max: 20 Units ($500,000)
Spouse: Min: 1 Unit – Max: 8 Units ($200,000)
Employee: Min: 1 Unit – Max: 4 Units ($100,000)
Final Year Student: Max: 1 Unit – Guaranteed Issue for a Final Year Student (1 Unit = $25,000) must apply within 12 months of graduation.

Built-in Features:

Waiver of Premium automatically built in. Must be totally disabled for 6 months before benefit kicks in. This benefit is built in; however, it can be denied only at initial underwriting and is only available to the member. A Conversion Privilege is also built in.

Optional Features:

Personal Accident Insurance Rider: Available to Members under age 65 and Final Year Students. Final Year Student guaranteed 1 unit if application is made during their final year and an additional unit is guaranteed if application is made within 12 months of graduation. A Member may choose up to $250,000 of coverage, either Single or Family coverage. If Family coverage is chosen, the Spouse receives 50% of the Members coverage and each child 14 days or older 10%. Children under 14 days receive $1,000. Children are insured to age 21 and 25 if attending school full time. Single coverage is $16 per unit annually and Family $24. Coverage terminates when Life Insurance terminates.

Rates:

Rates are defined by: Smoker, Non-smoker

Manulife Financial

CAO - EVIDENCE of INSURABILITY REQUIREMENTS - LIFE

TOTAL AMOUNT APPLIED FOR AND ISSUED BY MANULIFE WITHIN 12 MONTHS			
Amount	**Up to $100,000**	**$100,001 to $250,000**	**$250,001 to $500,000**
Age* Up to 50	Non-Med	Non-Med	Non-Med
51 to 55	Non-Med	Non-Med	Non-Med
56 to 60	Non-Med	Non-Med	Non-Med
61 to 70	Paramedical	Paramedical Blood Profile/Urine	Paramedical Blood Profile/Urine

*Means age at last birthday

Underwriting may request any additional requirement(s) deemed necessary based on declared history regardless of age or amount

EXCEPTION

- If only a small amount of additional coverage is applied for (within non-medical limit) and we obtained a paramedical & blood profile within the past 12 months, do not total coverage to determine requirements
- If applying for additional coverage with Manulife and no requirements have been ordered in the past, base the requirements on the total amount of insurance in force and pending, regardless of when the existing coverage was issued

LEGEND

NM: Non-medical (all questions on the application answered)
Blood Profile/urinalysis: Insurance blood profile including HIV antibody test and microscopic urinalysis
Paramedical: Medical history, height, weight, and blood pressure taken by a paramedical nurse

CANADIAN ASSOCIATION OF OPTOMETRISTS
PREMIUM RATES

Effective January 1, 2024

LIFE INSURANCE				
	Annual Premium per $25,000 Unit of Life Insurance			
	Male		Female	
Age	Standard	Non-Smoker	Standard	Non-Smoker
LT 30	$37.50	$25.00	$33.75	$25.00
30-34	$45.00	$28.75	$38.75	$28.75
35-39	$62.50	$37.50	$56.25	$36.25
40-44	$92.50	$57.50	$78.75	$55.00
45-49	$140.00	$90.00	$125.00	$71.25
50-54	$228.75	$138.25	$191.25	$109.50
55-59	$384.75	$219.50	$257.25	$165.00
60-64	$550.00	$320.25	$341.25	$235.25
65-69	$750.00	$469.50	$458.25	$323.25

ACCIDENTAL DEATH & DISMEMBERMENT RIDER

Annual Premium per $25,000 Unit of Life Insurance

Single	Family
$16.00	$24.00

Manulife

CANADIAN ASSOCIATION OF OPTOMETRISTS
ASSOCIATION CANADIENNE DES OPTOMÉTRISTES

Canadian Association of Optometrists Application for Insurance

CAO Multi-life Application
81401 001 20 (All Member coverages)
81401 002 20 (All Student coverages)

College Certificate of Registration number _____ /_____ /_____ /_____ /_____

1 MEMBER INFORMATION *(Please print)*

☐ I am a Member of the Canadian Association of Optometrists
☐ I am a Final Year Student applying for Guaranteed Issue Coverage
☐ I am a Final Year Student applying for Special Issue Coverage
☐ I am a New Applicant
☐ I am applying for Additional Coverage ***(Do not include coverage already in force)***
If currently insured under these plans, provide Certificate Number if known:
_____

☐ Dr. ☐ Other _____ ☐ Corporation *(or provide name of Partnership or Company)* _____

Last name	First name	Initial	Mailing address ☐ Home ☐ Business

Address (number, street and apt.)	City/Town	Province	Postal code

Sex ☐ Male ☐ Female	☐ Smoker ☐ Non-Smoker**	Date of birth (dd/mmm/yyyy)	Birthplace (City/Town and Country)

Email address	Telephone (Home) ( )	Telephone (Business) ( )

2 SPOUSE INFORMATION *(Complete only if applying for Spousal Term Life Rider Coverage)*

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Other _____

Last name	First name	Initial	Mailing address ☐ Same as above ☐ Other

Address (number, street and apt.)	City/Town	Province	Postal code

Sex ☐ Male ☐ Female	☐ Smoker ☐ Non-Smoker**	Date of birth (dd/mmm/yyyy)	Birthplace (City/Town and Country)

Email address	Telephone (Home) ( )	Telephone (Business) ( )

3 OTHER INSURANCE INFORMATION

Do you (Member or Spouse) have any pending or existing life insurance coverage with Manulife or any other company? ☐ Yes ☐ No
If ***yes***, complete the following:

Name of Applicant	Company name	Type of insurance	Personal or Business	Coverage amount	Will this coverage be replaced?
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract.
A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

4 INSURANCE PLAN CHOICES

Member Level Term Life Insurance (Member Term Life and Spouse Riders are available from $25,000 to $500,000 (increments of $25,000).)

Amount of coverage applied for $ _____

Spousal Level Term Life Insurance Rider (Available to Spouse provided an eligible Member is insured under the Member Level Term Life Insurance plan.)

Amount of coverage applied for $ _____

Personal Accident Rider (Available to Members who are insured for a minimum $25,000 under Member Term Life Insurance.)

☐ **Member $** _____ ☐ **Family $** _____

**** Non-Smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife's health standards.**

Accessible formats and communication supports are available upon request. Visit Manulife.ca/accessibility for more information.

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4 INSURANCE PLAN CHOICES *(continued)*

Income Protection Insurance Plan (Income Protection and Office Overhead Expense available to Members only from $500 to $8,000 (increments of $100).)

Waiting Period ☐ 14 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days*

Amount of coverage applied for $ _____

*Only available to employees.

Optional Riders

☐ Cost of Living Adjustment Rider
☐ Own Occupation Rider
☐ Future Purchase Option Rider

Office Overhead Expense Rider (Available to Members who are insured for a minimum of $500 of Income Protection Insurance.)

Waiting Period ☐ 14 days ☐ 30 days

Amount of coverage applied for $ _____

Optional Riders

☐ Future Purchase Option Rider

5 METHOD OF PAYMENT

☐ **Monthly by pre-authorized debit** – PAD (please enclose a sample cheque marked "VOID") Please complete Section A below

Payment Information

Section A: For pre-authorized debit (PAD) payment option

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

☐ **Annually** by cheque, payable to Manulife (please include it with your application)

$ _____ X _____ X _____ = $ _____

Total Monthly Premium	Number of months to January 1st (excluding current month)	Provincial Sales Tax if applicable	Amount Payable

Payment Authorization

Coverage begins on the date the completed application and required premium are received by Manulife, subject to final approval of the Company's underwriters.

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife 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 may attempt to withdraw that payment again within 30 days. Manulife 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 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 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 1-800-668-0195, am_service@manulife.ca or write to us at Manulife, 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, contact your financial institution or visit www.cdnpay.ca.

I/We hereby authorize Manulife 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 or by me/us through written notice.

Manulife 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.

Signature of Account Holder	Second Signature if Joint Account
✘	✘

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6 FINANCIAL INFORMATION *(Member to complete for all Products applied for)*

Member Occupation: _____

Annual Net Income (after expenses but before tax) $ _____

Personal Net Worth (assets less liabilities) $ _____

Describe duties and percentage of time performing each:

(Complete only if Spouse is applying for Spousal Level Term Life Insurance Rider)

Spouse Occupation: _____

Annual Net Income (after expenses but before tax) $ _____

Personal Net Worth (assets less liabilities) $ _____

Are you self-employed? ☐ Yes ☐ No If ***yes***, provide nature of business and description of duties.

_____

_____

Member complete the following if applying for Income Protection and/or Office Overhead Expense Insurance:

☐ **Sole Proprietor**	☐ **Partnership**	☐ **Associate**	☐ **An Employee** (Other than as an employee of your corporation)

☐ **Corporation -**

Give percentage of ownership: _____% If a shareholder employee of a professional corporation or a partner, give % of ownership: _____%

Total number of partners, shareholders, or associates in your practice: _____ If expenses are shared, what is your share?: _____%

☐ **Self-Employed -**

Since when: Month _____ Year _____

If less than 2 years, provide details of your previous employment history? _____

How many hours do you work per week? _____

Do you have any part time or other full time jobs? ☐ Yes ☐ No If ***yes***, provide details: _____

Do you expect your income or employment situation to change within the next 12 months? ☐ Yes ☐ No

If ***yes***, provide details: _____

If your total coverage from all sources will exceed $3,500/month, please provide a copy of your last personal income tax return (a Notice of Assessment is not acceptable). If incorporated, also provide a copy of your last Corporate Financial Statement (all pages). If you are purchasing an existing practice, also provide a copy of the last Financial Statement (all pages) from the practice you are purchasing.

Complete the following only if applying for Income Protection Insurance Plan:

1. What was your net annual earned income (after regular business expenses but before taxes)?

   Last year: $_____ 2 years ago: $_____

2. Is your net worth (assets minus liabilities other than personal use assets such as residence, automobile, jewelry) greater than $4,000,000? ☐ Yes ☐ No
3. Do you have any income which will become payable or continue should you become disabled? ☐ Yes ☐ No
4. Is your unearned or investment income for last year greater than $30,000.00 or 15% of your insurable Net Annual Earned Income? ☐ Yes ☐ No
5. Are you eligible for employment insurance? ☐ Yes ☐ No

Complete the following only if applying for Office Overhead Expense Rider:

I declare my total monthly business expenses are: $_____

7 UNDERWRITING QUESTIONNAIRE

- **Questionnaire MUST be entirely completed, even if all health questions are answered no.**
- **This application is not valid unless the Underwriting Questionnaire is fully completed and the application is signed.**

Member:

Member name			Member's physician name	
Physician's address (number, street, suite)	City/Town	Province	Postal code	Telephone ( )
Date last seen (dd/mmm/yyyy)	Reason last seen			
Tests, treatment, medication prescribed (If none, state *none*)				
Results and current status				

Weight	Height	Has your weight changed in the past year?	If ***yes,***	Reason for change
☐ _____ kg ☐ _____ lb	☐ _____ ft/in ☐ _____ cm	☐ Yes ☐ No	☐ Gained _____ lb/kg ☐ Lost _____ lb/kg	

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7 UNDERWRITING QUESTIONNAIRE *(continued)*

- **Questionnaire MUST be entirely completed, even if all health questions are answered no.**
- **This application is not valid unless the Underwriting Questionnaire is fully completed and the application is signed.**

Spouse:

Spouse's name (if applying)		Spouse's physician name		
Physician's address (number, street, suite)	City/Town	Province	Postal code	Telephone ( )
Date last seen (dd/mmm/yyyy)	Reason last seen			
Tests, treatment, medication prescribed (If none, state *none*)				
Results and current status				

Weight	Height	Has your weight changed in the past year?	If ***yes,***	Reason for change
☐ _____ kg ☐ _____ lb	☐ _____ ft/in ☐ _____ cm	☐ Yes ☐ No	☐ Gained _____ lb/kg ☐ Lost _____lb/kg	

Your Personal Information

Have you:	Member	Spouse
1. Ever applied for any insurance that was declined, modified or rated? If ***yes***, give details including date, name of company and reason:	☐ Yes ☐ No	☐ Yes ☐ No
2. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your license suspended or revoked? If ***yes***, provide details, including the number of charges and convictions and date of last conviction. In case of a license suspension or revocation, provide details including date the license was suspended or revoked.	☐ Yes ☐ No	☐ Yes ☐ No
b) Within the past 2 years, been charged with or convicted of 2 or more moving or traffic violations? (for example, speeding, failure to stop, seat belt violations, distracted driving, or failure to provide a breathalyzer sample) If ***yes***, please provide full details; nature of offence(s), date(s), driver's license number and licensing province:	☐ Yes ☐ No	☐ Yes ☐ No
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):	☐ Yes ☐ No	☐ Yes ☐ No
4. a) Within the next 12 months do you expect to travel outside of Canada and the United States of America? If ***yes***, give details including where, when, why and for how long.	☐ Yes ☐ No	☐ Yes ☐ No
b) Do you expect to change your country of residence? If ***yes***, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing:	☐ Yes ☐ No	☐ Yes ☐ No
5. Within the past 5 years: a) Used any drugs for other than medical purposes, used marijuana, or been advised, treated or counselled for alcohol or drug abuse? If ***yes***, give details including drug or alcohol type(s) and date(s) last used:	☐ Yes ☐ No	☐ Yes ☐ No
b) Been convicted of a criminal offense or are you currently charged with one? If ***yes***, please provide details:	☐ Yes ☐ No	☐ Yes ☐ No
c) Declared, or are contemplating personal or business bankruptcy? If ***yes***, provide details including date of discharge:	☐ Yes ☐ No	☐ Yes ☐ No

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7 UNDERWRITING QUESTIONNAIRE *(continued)*

• Questionnaire MUST be entirely completed, even if all health questions are answered no.

Your Medical Information

1. Have you ever had any indication of or been treated for conditions involving any of the following:	**Member**	**Spouse**
a) **Your heart or blood vessels,** such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐ Yes ☐ No	☐ Yes ☐ No
b) **Your nose, throat or lungs,** such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐ Yes ☐ No	☐ Yes ☐ No
c) **Your abdominal organs,** such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐ Yes ☐ No	☐ Yes ☐ No
d) **Your kidneys, bladder or reproductive organs,** such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐ Yes ☐ No	☐ Yes ☐ No
e) **Your breast,** such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐ Yes ☐ No	☐ Yes ☐ No
f) **Your brain or nervous system,** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐ Yes ☐ No	☐ Yes ☐ No
g) **Your eyes or ears,** such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐ Yes ☐ No	☐ Yes ☐ No
h) **Your mental health,** such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐ Yes ☐ No	☐ Yes ☐ No
i) **Your blood or glands,** such as: Diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, bleeding tendency, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐ Yes ☐ No	☐ Yes ☐ No
j) **Your muscles, bones, or joints,** such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?	☐ Yes ☐ No	☐ Yes ☐ No
k) **Your skin,** such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles, or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐ Yes ☐ No	☐ Yes ☐ No
l) **Your immune system,** such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐ Yes ☐ No	☐ Yes ☐ No
m) Cancer, cysts, lumps, polyps, or tumour?	☐ Yes ☐ No	☐ Yes ☐ No
n) Other illness or disorder not mentioned above or, are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐ Yes ☐ No	☐ Yes ☐ No
2. a) Are you currently pregnant? If ***yes***, give due date: _____ Name of obstetrician/gynecologist: _____ Address of obstetrician/gynecologist: _____	☐ Yes ☐ No	☐ Yes ☐ No
b) What was your pre-pregnancy weight _____lb _____kg c) Have there been any complications with your pregnancy? If ***yes***, provide details	☐ Yes ☐ No	☐ Yes ☐ No

3. These questions are not applicable to term life applicants. ***(Complete if applying for Income Protection Insurance)***	**Member**	**Spouse**
a) Been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain sciatica, or other?	☐ Yes ☐ No	☐ Yes ☐ No
b) Had X-rays (including the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐ Yes ☐ No	☐ Yes ☐ No
c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	☐ Yes ☐ No	☐ Yes ☐ No
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	☐ Yes ☐ No	☐ Yes ☐ No

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7 UNDERWRITING QUESTIONNAIRE *(continued)*

• Questionnaire MUST be entirely completed, even if all health questions are answered no.

4. Within the past 2 years, have you:

		Member	Spouse
a)	Had an abnormal mammogram, PSA or any other test or investigation?	☐ Yes ☐ No	☐ Yes ☐ No
b)	Consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu, etc.)?	☐ Yes ☐ No	☐ Yes ☐ No
c)	Been advised to undergo further investigation, seen another doctor or have surgery?	☐ Yes ☐ No	☐ Yes ☐ No
d)	Or presently, are you unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered ***yes*** to Medical Questions above, please give details below:

Name of Applicant	Question number	Nature of Disorder	Date and Duration	Treatment (If none, state *none*) & Current Status	Attending Physician or Hospital

5. Your Family Medical History

		Member	Spouse
a)	Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
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?	☐ Yes ☐ No	☐ 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

8 BENEFICIARY DESIGNATION *(Complete if applying for Level Term Life Insurance)*

I (the Member) designate the individual(s) named as beneficiary(ies) 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(ies):

Last name	First name	Relationship	% of Benefit
Last name	First name	Relationship	% of Benefit

Spouse Term Life Rider Beneficiary Designation

I (the Member) designate the individual(s) named as beneficiary(ies) 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 Member.

Beneficiary(ies):

Last name	First name	Relationship	% of Benefit
Last name	First name	Relationship	% of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

Last name	First name	Relationship to the beneficiary

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Insurance is underwritten by

The Manufacturers Life Insurance Company (Manulife).

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9 DECLARATIONS AND AUTHORIZATIONS *(Please read carefully before signing)*

I (the Member) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

I/We declare that the statements contained in this application, including but not limited to the Health Declaration originally attached hereto, are true and complete and, together with any other forms signed by me/us in connection with this application, form the basis for any certificate/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, and that suicide within two years of the effective date is a risk not covered. I/We understand that other exclusions and limitations will apply to the coverage applied for. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, MIB, Inc., any insurance company, agent, broker, market intermediary, plan sponsor, group policy administrator 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 such information to Manulife or its reinsurers for the purpose of this application, any certificate/policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We understand that in connection with this application, Manulife may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant and that any positive infectious disease results will be reported to the appropriate health department if required by law. I/We understand the reason why the health information is needed and the risks and benefits of consenting or refusing to consent.

I/We understand that insurance will take effect on the first day of the month following the date my/our properly completed application (including the Health Declaration) and the first premium are received by Manulife, subject to approval of the company's underwriters. If my/our application is approved, I/we will receive a certificate/policy specifying the coverage provided and the main certificate/policy provisions.

I/We acknowledge my/our receipt of and agreement with the Notice on Privacy and Confidentiality.

A copy, fax, scan or image of this signed authorization shall be as valid as the original.

Notice of Exchange of Information:

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Manulife or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (416) 597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. Information for consumers about MIB may be obtained on its website at www.mib.com.

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife 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 jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, ON, N2J 4C6.

I (the Member) hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

Member's signature ✘	Signed at (City/Town)	Date (dd/mmm/yyyy)
Spouse's signature (if applying for spousal coverage) ✘	Signed at (City/Town)	Date (dd/mmm/yyyy)

QUESTIONS? CALL MANULIFE

Toll-Free: **1-800-668-0195** or email: **am_service@manulife.ca**

Please send your completed application, along with payment, to:
Manulife, P.O. Box 670, STN Waterloo, Waterloo ON N2J 4B8

RESET PRINT SAVE AS

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The Manufacturers Life Insurance Company (Manulife).

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