Long Term Disability Insurance Application Guide

An exclusive offer for CAO members

Thank you for your interest in Long Term Disability (LTD) Insurance through the Canadian Association of Optometrists (CAO). This application package has been designed to make it easy to apply for LTD 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 $100 monthly benefit amounts, and the premium rates depend on your age bracket, your gender, your smoking status, and the elimination period you select. For example, if you would like a monthly benefit of $2,500, you would need 25 units of coverage.

You have a number of options to choose from when designing your LTD coverage. You may choose from a number of **elimination periods**, which refers to how many days you must wait before submitting a claim for disability benefits. You should determine how long you would be able to manage without income if you were to become disabled and select an elimination period that best aligns with your needs.

There are also a number of riders, or additional benefits, you may wish to add to your disability coverage. The **Future Purchase Option** allows you to increase coverage at a later date as your financial needs change, without having to provide updated medical evidence. The **Own Occupation to Age 65** rider ensures that you are not requested to find "any job" to remove you from disability benefits after a period of time (two years is common). **Office Overhead Insurance** will replace the costs associated with running your office (rent, utilities, employees' salaries).

The LTD 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. Your premiums are based on your age at January 1st of each year; as you enter a new age bracket, you will experience an increase in premium rates.

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 disability insurance needs.

We hope you find this application guide helpful. If you have any questions at any time, please don't hesitate to get in touch with one of our dedicated CAO brokers by emailing:

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

Long Term Disability – Income Protection – CANADIAN ASSOCIATION OF OPTOMETRISTS

Eligibility

Eligibility Requirements:

- Members of the CAO and Employees of the CAO
- Working full time (minimum 30 hours per week)
- Under 65 at time of application.
- **Final Year Students** and **First Year Graduates** are also eligible

Coverage Detail:

Long Term Disability – Value Per Unit = $100

Benefit Levels

Members & Employees:	Minimum $500, maximum $8,000
First Year Students:	5 Units ($500/month maximum)
First Year Graduates:	5-20 Units ($500/month to $2,000/month
Final Year Students: ** **Not subject to financial underwriting**	Minimum $500, maximum $2,000

Elimination Periods

Member:	14, 30, 60, and 90 days
Employees:	120 days

Benefit Periods

Injury prior to age 64:	Lifetime
Between 64-70:	24 months
Illness prior to age 64:	To age 65
Between 64-65:	24 months

Guaranteed Issue:

Final Year Students are guaranteed $500 during their final year and an additional $500 within 12 months of graduation.

Built-in Features:

Waiver of Premium after 3 months disability or elimination period (whichever is longer). Premium waived until date benefits cease. **5 year Own Occupation built in.**

Optional Features Cost of Living Rider:

Available to Members and full time Employees of the CAO who are applying for LTD (after 12 months of total or partial disability pays the lesser of 8% or the change in C.P.I. terminates when the LTD ends, when the monthly benefit doubles, or attainment of age 65).

- Must be under age 65 to apply.

LTD Future Purchase Option Rider:

- Available to Members and full time Employees of the CAO, under the age of 50 at time of application.
- The rider provides for the purchase of up to $2,000 of additional coverage on a non-medical underwritten basis. Financial underwriting will apply.
- Four options may be exercised with a maximum of $500 on each option date.
- Options may be exercised within 30 days prior to January 1 of even numbered calendar years.
- Coverage terminates at age 50.

Own Occupation Rider:

- Available to Members under age 63.
- This rider changes the definition of Total Disability to being unable to perform the duties of Optometry.
- Terminates at age 65.

Office Overhead Expense Rider:

- Members can purchase a minimum of $500 to a maximum of $8,000.
- The benefit period is 12 months. Elimination periods are 14 and 30 days.
- Available to Members under age 65 who are insured for or applying for a minimum of $500 of LTD.
- No proof of expenses required. Declaration is adequate.
- First Year Graduates are guaranteed $500 provided they have LTD and apply within 12 months of graduation. Their elimination period is 30 days.

Office Overhead Future Purchase Option:

- Same as LTD Future Purchase Option.
- Only a declaration of expenses is required to exercise the option. No Proof of Expenses required.

Rates:

Smoker, Non-smoker, Gender, Age, 10 year banded

LTD Proof of Income:

Up to $3,500/month – None
Over $3,500/month – Employee: Pages 1, 2, and 3 of past two years' tax returns
Self-Employed Unincorporated: Pages 1, 2, and 3 of past 2 years' tax returns.
Self Employed Incorporated: Pages 1, 2, 3 or past 2 years' tax returns plus latest corporate financial statement.

Substandard risks:

Substandard ratings not available. Maximum of 3 exclusions allowed.

Manulife Financial

CANADIAN ASSOCIATION OF OPTOMETRISTS		
Disability and Office Overhead Expense - Medical Underwriting Requirements		
Effective November 7, 2022		
AGE	*MONTHLY AMOUNT WITHIN 12 MONTHS	REQUIREMENT
Up to Age 40		
	Up to $2,500	Non-medical
	$2,501 - $6,000	Non-medical
	$6,001 - $10,000	Non-Medical, Urinalysis
	$10,001 and up	Paramedical, Blood Profile, Urinalysis
Age 41 to 50		
	Up to $2,500	Non-Medical
	$2,501 - $6,000	Non-Medical, Urinalysis
	$6,001 - $10,000	Paramedical, Blood Profile, Urinalysis
	$10,001 and up	Paramedical, Blood Profile, Urinalysis
Age 51 to 64		
	Up to $2,500	Non-Medical
	$2,501 - $6,000	Paramedical. Blood Profile, Urinalysis
	$6,001 - $10,000	Paramedical, Blood Profile, Urinalysis, APS
	$10,001 and up	Paramedical, Blood Profile, Urinalysis, APS

Monthly Benefit Amount is calculated by adding:

- 100% of basic Disability coverage, plus
- 50% of Office Overhead Expense, if applied for, plus
- 50% of Future Purchase Option Rider (FPO), if issue age is 18-40 or 25% of the amount if issue age is 41 or older

Important Notes

- All health care workers who perform invasive procedures or are exposed to blood products require a blood profile with a Hepatitis screen.
  Exception will be given t those who can confirm that they have already been vaccinated.
- Attending Physician's Statements (APS), and Motor Vehicle Reports (MVR) are ordered by Head Office.
- We reserve the right to request any reports or tests at any age or amount when considered necessary based on our assessment of the risk.
- Use of other company's medical papers is allowed provided all of our routine requirements are included.
- Medical requirements are deemed current for a period not exceeding 12 months.
- **Executive Physical**: if the applicant has undergone an executive physical within the 12 months previous to the application date, please provide copies of all results with application and do not order any routine age and amount requirements. We may be able to use the results from the executive physical in lieu of routine age and amount requirements. We will review the results of the executive physical and advise if any additional requirements are necessary.

To determine the Monthly Amount for Overhead Coverage, with inforce CAO LTD

- If purchased within 12 months of the LTD – add all LTD amounts plus 50% of all FIO amounts (existing and applied) plus ½ OE amount.
- If purchased outside 12 months of the LTD – 50% of the OE amount plus 50% FIO on OE

Proof of Income Requirements:

Amount of disability coverage from all sources (amount applied for plus existing coverage)

Up to $3,500/month –	None
Over $3,500/month –	Employee: Pages 1, 2, 3 of past two years' tax return Self-Employed Unincorporated: Pages 1, 2, 3 of past 2 years' tax returns Self-Employed Incorporated: Pages 1, 2, 3 of past 2 years' tax returns plus latest Corporate Financial Statement

No proof of expenses is required. Declaration is adequate.

Maximum Disability Amount - $8,000
Maximum Overhead Expense Amount - $8,000

CANADIAN ASSOCIATION OF OPTOMETRISTS

Underwriting Guidelines – Income Qualification Table

Your Net Annual Earned Income	Your Net Monthly Earned Income	Maximum Allowable Monthly Benefit From All Sources	Your Net Annual Earned Income	Your Net Monthly Earned Income	Maximum Allowable Monthly Benefit From All Sources
$18,000	$1,500	$1,200	$90,000	$7,500	$4,700
$19,000	$1,583	$1,300	$91,000	$7,583	$4,800
$21,000	$1,750	$1,400	$93,000	$7,750	$4,900
$23,000	$1,917	$1,500	$96,000	$8,000	$5,000
$25,000	$2,083	$1,600	$99,000	$8,250	$5,100
$27,000	$2,250	$1,700	$102,000	$8,500	$5,200
$29,000	$2,417	$1,900	$105,000	$8,750	$5,300
$31,000	$2,583	$2,000	$107,000	$8,917	$5,400
$33,000	$2,708	$2,100	$109,000	$9,083	$5,500
$36,000	$3,000	$2,200	$112,000	$9,333	$5,600
$38,000	$3,167	$2,300	$114,000	$9,500	$5,700
$39,000	$3,250	$2,400	$117,000	$9,750	$5,800
$41,000	$3,417	$2,500	$120,000	$10,000	$5,900
$43,000	$3,583	$2,600	$123,000	$10,250	$6,000
$45,000	$3,750	$2,700	$126,000	$10,500	$6,100
$47,000	$3,917	$2,800	$128,000	$10,667	$6,200
$50,000	$4,167	$2,900	$130,000	$10,833	$6,300
$53,000	$4,417	$3,000	$133,000	$11,083	$6,400
$55,000	$4,583	$3,100	$135,000	$11,250	$6,500
$56,000	$4,667	$3,200	$137,000	$11,417	$6,600
$57,000	$4,750	$3,300	$139,000	$11,667	$6,700
$61,000	$5,083	$3,400	$144,000	$12,000	$6,800
$63,000	$5,250	$3,500	$148,000	$12,333	$6,900
$65,000	$5,417	$3,600	$150,000	$12,583	$7,000
$67,000	$5,583	$3,700	$153,000	$12,833	$7,100
$70,000	$5,833	$3,800	$156,000	$13,083	$7,200
$72,000	$6,000	$3,900	$158,000	$13,167	$7,300
$74,000	$6,167	$4,000	$160,000	$13,333	$7,400
$77,000	$6,417	$4,100	$164,000	$13,667	$7,500
$79,000	$6,542	$4,200	$168,000	$14,000	$7,600
$80,000	$6,667	$4,300	$170,000	$14,167	$7,700
$83,000	$7,000	$4,400	$173,000	$14,417	$7,800
$86,000	$7,167	$4,500	$176,000	$14,667	$7,900
$88,000	$7,333	$4,600	$180,000	$15,000	$8,000

CAO LONG TERM DISABILITY (INCOME PROTECTION) PREMIUM RATES

Effective January 1, 2024

Age	Annual Premium per $100 Unit of Monthly Benefit Elimination Period 14 Days	30 Days	60 Days	90 Days	120 Days
LT 30	$14.50	$11.90	$9.25	$8.00	$6.75
30-39	$17.40	$14.90	$12.25	$11.00	$9.75
40-49	$32.75	$29.15	$23.75	$21.40	$20.00
50-59	$61.00	$52.25	$44.65	$41.00	$38.65
60-69	$82.65	$71.00	$59.00	$50.65	$45.00

LONG TERM DISABILITY FUTURE PURCHASE OPTION RIDER (FPO)

Annual cost is $40.00 regardless of Number of Units

OWN OCCUPATION TO AGE 65 RIDER

Annual cost is 20% of the Income Protection (LTD) Premium

COST OF LIVING RIDER

Age	Annual Cost Per $100 Unit
LT 30	$5.25
30-39	$7.35
40-49	$10.55
50-59	$13.70
60-69	$9.50

CAO OFFICE OVERHEAD INSURANCE

Age	Annual Premium per $100 Unit of Monthly Benefit Elimination Period 14 Days	30 Days
LT 30	$12.00	$8.70
30-39	$14.25	$9.80
40-49	$20.00	$13.90
50-59	$30.75	$23.00
60-69	$42.00	$32.20

OFFICE OVERHEAD FUTURE PURCHASE OPTION RIDER (FPO)

Annual cost is $40.00 regardless of Number of Units

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	

Insurance is underwritten by

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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.

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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

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