Manulife

Group Benefits
Application for Optional Life Insurance for Plan Member, Spouse and Child(ren) for Head Office Plans

CONDITIONS FOR ELIGIBILITY

By signing the Authorization section of this Application, I understand that for me to qualify for coverage up to $100,000 and for my spouse to qualify for coverage up to $50,000 without completing a detailed medical questionnaire, the person(s) whom I seek to insure under this application must be in good health.

I **declare** that the person(s) whom I seek to insure is (are) in good health and that any adult(s) to be insured does (do) not have any physical or mental conditions that prevent them:

(a) if they are employed, from regularly attending to their occupation, or

(b) if they are not employed, from being so employed if they chose to engage in an occupation.

I **declare** that the person(s) whom I seek to insure has (have) never been declined when they have either applied for or been the subject of any application for life insurance coverage with any insurer, or other entity.

I also **understand** that if this application is approved by Manulife, the contract will contain an exclusion under which benefits will not be paid for any pre-existing medical conditions during the first 24 months.

INSTRUCTIONS – PLEASE PRINT ALL ANSWERS

1. *Please consult your plan administrator for type of coverage available under your plan. Check (✓) to indicate the type of coverage for which you are applying.*
   ◯ *PLAN MEMBER ONLY* ◯ *PLAN MEMBER AND SPOUSE* ◯ *PLAN MEMBER, SPOUSE AND CHILDREN*
   ◯ *PLAN MEMBER AND CHILDREN* ◯ *SPOUSE AND/OR CHILDREN*
2. *Please ensure that ALL SECTIONS are completed.*
3. *Section 5 - Medical information **and** Section 6 - Medical questionnaire are required and **MUST BE COMPLETED** only if the plan member total amount requested is over $100,000 and/or the spouse's total amount requested is over $50,000.*
4. ***If required, retain a photocopy for your files.***

1 Plan sponsor information

Plan contract number(s)	Plan member certificate number

Plan sponsor

Coverage being applied for:

OPTIONAL LIFE

◯ **Plan member optional life amount:** ☐ Dollar amount

Plan member's present amount of optional life	$_____
Additional amount requested	$_____
Total amount requested	$_____

◯ **Spousal optional life amount:** ☐ Dollar amount

Spouse's present amount of optional life	$_____
Additional amount requested	$_____
Total amount requested	$_____

◯ **Child(ren) optional life amount:** ☐ Dollar amount

Child(ren)s present amount of optional life	$_____
Additional amount requested	$_____
Total amount requested	$_____

2 Plan member information

Required if applying for plan member, spousal or child(ren) coverage.

Plan member name (last, first and middle initial)

Date of birth (dd/mmm/yyyy)

Language preference
◯ English ◯ French

Sex assigned at birth
◯ Male ◯ Female

Province of residence

By providing my personal email address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.

Email address

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months?
◯ Yes ◯ No

3 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

Name of beneficiary (last, first and middle initial)

Relationship to plan member

Additional name, if applicable (last, first and middle initial)

Relationship to plan member

Additional name, if applicable (last, first and middle initial)

Relationship to plan member

For designated beneficiaries under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority.

Irrevocability

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, the designation is:
◯ Revocable ◯ Irrevocable

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

4 Spousal coverage

Required if applying for spousal coverage.

Note: you will be the beneficiary of your spouse's insurance, if you are then living, otherwise the beneficiary will be your estate.

Spouse's name (last, first and middle initial)

Date of birth (dd/mmm/yyyy)

Sex assigned at birth
◯ Male ◯ Female

Has your spouse smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months?
◯ Yes ◯ No

5 a) Plan member basic medical information

Only required if applying for total coverage over $100,000.

Section 5 - Complete only if applying for a total plan member coverage amount over $100,000 and spousal coverage over $50,000.

Height

_____ m _____cm _____ ft _____ in

Weight ◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs. during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason

Name of personal physician (last, first and middle initial)

Physician's phone number ( )

Address of personal physician (number, street, suite)

City

Province

Postal code

5 b) Spouse basic medical information

Only required if applying for total spousal coverage over $50,000.

Height

_____ m _____cm _____ ft _____ in

Weight ◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs. during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason

Is name of personal physician the same as plan member's? ◯ Yes ◯ No If *no*, please provide:

Name of personal physician (last, first and middle initial)

Physician's phone number ( )

Address of personal physician (number, street, suite)

City

Province

Postal code

6 Medical questions for proposed insured

Complete only if applying for total plan member coverage over $100,000 and spousal coverage over $50,000.

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers please attach a separate sheet (signed and dated).

	Plan member	Spouse
1. During the past 12 months have you		
(a) flown as a pilot, student pilot or crew member or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you		
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◯ No	◯ Yes ◯ No
(b) ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No
(c) been absent from work for medical reasons during the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
(d) currently received any treatment/medications?	◯ Yes ◯ No	◯ Yes ◯ No
(e) In the past 60 days, have you consulted a doctor or other health practitioner, had medical testing done for anything other than pregnancy or minor ailments (e.g. sprains, cold or flu)?	◯ Yes ◯ No	◯ Yes ◯ No
(f) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◯ No	◯ Yes ◯ No
(g) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)?	◯ Yes ◯ No	◯ Yes ◯ No
3. Have two or more immediate family members (e.g. your parents or siblings) been diagnosed before age 50 with heart disease, stroke or cancer?	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you ever consulted a physician, ever been treated for, or had any known identification of		
(a) Chest pain, blood vessel disease, heart disorder, heart attack, heart murmur, angina cardiac bypass surgery, stent placement or angioplasty, or stroke?	◯ Yes ◯ No	◯ Yes ◯ No
(b) high blood pressure?	◯ Yes ◯ No	◯ Yes ◯ No
(c) allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◯ No	◯ Yes ◯ No
(d) glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
(e) epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinsons)?	◯ Yes ◯ No	◯ Yes ◯ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◯ No	◯ Yes ◯ No
(g) Have you ever been treated for, counselled, or advised to seek treatment for alcohol or drug abuse?	◯ Yes ◯ No	◯ Yes ◯ No
(h) In the past 12 months have you used or smoked marijuana or hashish?	◯ Yes ◯ No	◯ Yes ◯ No
(i) In the past 12 months have you smoked cigars? If *yes*, how many cigars have you smoked?	◯ Yes ◯ No	◯ Yes ◯ No
(j) lung disorders or shortness of breath?	◯ Yes ◯ No	◯ Yes ◯ No
(k) ulcer, colitis, bowel, stomach, reproductive organs or liver disorders?	◯ Yes ◯ No	◯ Yes ◯ No
(l) cancer?	◯ Yes ◯ No	◯ Yes ◯ No
(m) sexually transmitted disease, urinary tract infection, disorder of the kidney, blood, urine, or genital organs?	◯ Yes ◯ No	◯ Yes ◯ No
(n) arthritis, rheumatism or fibromyalgia?	◯ Yes ◯ No	◯ Yes ◯ No
(o) disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◯ No	◯ Yes ◯ No
(p) immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	◯ Yes ◯ No	◯ Yes ◯ No
(q) anemia, or other blood disorders?	◯ Yes ◯ No	◯ Yes ◯ No
5. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	◯ Yes ◯ No	◯ Yes ◯ No

Please provide details below, if you have answered "Yes" to *ANY* questions. If more space is needed, use another form or sheet of paper (both must be signed and dated).

Question number	Name of person (first & middle initial)	Details or name of condition	Date and duration	Medication/treatment and results (recovery or remaining effects)	Names and addresses of physicians and hospitals

7 Certification and authorization

I certify that I (being the plan member or spouse with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/planmember, or from my Plan Sponsor.

Plan member signature	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

PRINT

8 Mailing instructions

Send a scanned copy to us by

Email: EOI_Intake_Shared_Services@manulife.com

Plan Member Website: Use the link under Contact Us in the main menu to send us your documents securely using the Send Documents feature.

OR Mail to: Plan Member Administration
Manulife
PO BOX 11006 STN CENTREVILLE
MONTREAL QC H3C 4T8