The Manufacturers Life Insurance Company

Manulife

The Association
Health & Dental Plan

HEALTH & DENTAL PLAN APPLICATION

All applicants must complete Parts A, B, C, D and Section A.
All applicants must complete and sign Applicant's Authorization and Declaration.

For Manulife Use Only.
Keyed _____
Approval _____

zzz

Agent ID
SB000

Logo ID

Part A • General Information

Applicant's Last Name _____ First Name _____ Initial _____ Does each applicant have provincial/territorial health care coverage?* ❑ Yes ❑ No

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

City or Town _____ Province Select Province Postal Code _____ Occupation _____

Co-Applicant's Last Name _____ First Name _____ Co-Applicant's Occupation _____

Applicant's Office Telephone ( ) _____ Co-Applicant's Office Telephone ( ) _____

Applicant's E-mail _____ Co-Applicant's E-mail _____

If additional information is required, how may we contact you? ❑ Home ❑ Office ❑ E-mail Best time to call _____ AM PM

*All applicants must have coverage under a provincial/territorial health care insurance plan in order to be eligible for this insurance product. If anyone on the application does not meet this requirement, please contact our Customer Service for more information.

Are you now covered by or did you recently have employer group health insurance coverage? ❑ Yes ❑ No

If "Yes", please indicate:

Group Plan Number _____ ID Number _____

Insurance Company _____ Date Benefits Ended _____ (DD/MMM/YYYY)

Group Plan Number _____ ID Number _____

Insurance Company _____ Date Benefits Ended _____ (DD/MMM/YYYY)

Note for Quebec residents:

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

If you intend to replace coverage other than your current or recently ended group health plan, do not cancel your existing coverage. Manulife may not be able to issue a policy where replacement of an existing insurance product is intended. The prescription drug coverage available under this plan is limited to costs not covered by the RAMQ Prescription Drug Insurance Plan. It is not intended to be a replacement for the RAMQ Plan. In order to be eligible for coverage under this Plan, you must have a provincial health card and be registered under the RAMQ Prescription Drug Insurance Plan, or have equivalent coverage under a group plan.

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

Applicant's Beneficiary

Name _____

Relationship to Applicant _____

% of Benefit _____

Co-Applicant's Beneficiary

Name _____

Relationship to Applicant _____

% 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.

Name of Trustee _____

Relationship to Beneficiary _____

Name of Trustee _____

Relationship to Beneficiary _____

For Quebec residents only:

In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.
(Check box below if designation is to be revocable.)

❑ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

❑ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Part B • Plan Choice

Remember: Your Plan Choice applies to all family members.

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 the Applicant's Authorization and Declaration.

Part C • Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, $ _____ , using my/our:

Option #1 ❑ Pre-Authorized Debit (PAD)

Option #2 ❑ Credit Card Account

IMPORTANT: Initial Payment will be taken on the **day approved** (not the effective date). Future payments will be taken on the first of each month.

Subsequent Payments will be made by:

Option #1 ❑ Pre-Authorized Debit (PAD)

PAD Billing Frequency: ❑ Monthly ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

Important: For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part D.

Option #2 ❑ Credit Card Account

Credit Card Billing Frequency: ❑ Monthly ❑ Semi-Annually ❑ Annually

Please note: Billing frequency discounts are not available for credit card payment options. Please complete Part D.

Option #3 ❑ Direct Billing

Direct Billing Frequency: ❑ Semi-Annually (2% discount) ❑ Annually (4% discount)

Part D • Payment Information and Authorization

Credit Card Option Payment Information & Payment Authorization

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.

Credit Card: ❑ American Express ❑ MasterCard ❑ Visa

Card Number _____ Expiry Date _____ (MM/YYYY)

Name of Cardholder _____ Signature of Cardholder _____

Second signature if Joint Account _____ Dated _____ (DD/MMM/YYYY)

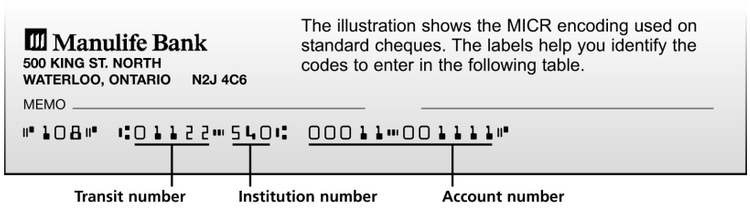
Pre-Authorized Debit (PAD) Payment Information & Payment Authorization

Please use the following banking information:

❑ From the cheque used to make the first payment

OR

❑ As follows: (only complete the table below if you do not have a void cheque)



The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.

Transit Number _____ Institution Number _____ Bank Account Number _____

Financial Institution _____ Address _____

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.

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 1-800-268-3763, or more_info@manulife.com 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.

Name of Account Holder _____ Signature of Account Holder _____

Second Signature if Joint Account _____ Dated _____ (DD/MMM/YYYY)

Account Holder Address (if different from Applicant) _____

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 final approval of this application.

Additional medical information may be required to underwrite your application.

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

All applicants must complete and sign the Applicant's Authorization and Declaration.

Quebec residents may detach and mail the Medical Questionnaire portion to the insurer.

If you are detaching and mailing your Association Health & Dental Medical Questionnaire to Manulife separately, please complete the following:

Applicant's Last Name _____ First Name _____ Initial _____ Home Telephone ( ) _____

Section A • Individuals To Be Covered

FIRST NAME	LAST NAME	CODE	SEX	BIRTH DATE DD MMM YYYY	AGE	SMOKER NO. OF CIGARETTES DAILY	HEIGHT (cm/inch)	WEIGHT (kg/lb)	WEIGHT CHANGE IN LAST YEAR GAIN LOSS	REASON FOR WEIGHT CHANGE
APPLICANT		01								
CO-APPLICANT		02								
DEPENDENT CHILD		02								
DEPENDENT CHILD		02								
DEPENDENT CHILD		02								
DEPENDENT CHILD		02								

Section B • Treating Qualified Health Care Practitioner

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

Name and telephone number 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 Applicant	For Co-Applicant	For Dependant(s)
Name of Primary Health Care Provider			
Telephone number of Primary Health Care Provider			
Date of last consultation			
Reason for last consultation			
Diagnosis made			
Treatment given			

Name and telephone number **of any other** Qualified Health Care Practitioner consulted or referred to: _____

Name of person who consulted other Practitioner: _____

Date and reason for consultation: _____

Section C • Simplified Underwriting Questionnaire

Must be completed in full for Bronze Health & Dental, Silver Health & Dental and Gold Health & Dental plans.

Have you, your co-applicant or any listed dependant(s):

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 or complaint 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 medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? (Do not include any minor ailments such as the cold or flu.) ❑ Yes ❑ No

If any questions in Section C are answered "Yes," please complete Section D in full.

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 final approval of this application.

All applicants must complete and sign the Applicant's Authorization and Declaration.

Section D • Medical Declaration

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: (✓ "Yes" or "No" to all questions)

a) High Blood Pressure, High Cholesterol, any Circulatory or Blood Disorder ❑ Yes ❑ No

b) Heart or Blood Vessel Disorder, Heart Murmur, Chest Pain, Angina, Stroke or Transient Ischemic Attack (TIA) ❑ Yes ❑ No

c) Back, Neck, Disc, Hip, Knee or Joint Pain or Disorder, Fibromyalgia, Osteoporosis, Osteopenia, Chronic Pain, Paralysis, Weakness or Numbness, or any other Musculoskeletal Pain or Disorder ❑ Yes ❑ No

d) Digestive System Disorder, Crohn's Disease, Ulcerative Colitis, Liver Disease or Disorder including Hepatitis or Hepatitis Carrier State ❑ Yes ❑ No

e) Mental, Nervous, Emotional or Neurological Disorder including Depression, Anxiety, Attention Deficit Disorder or Stress ❑ Yes ❑ No

f) Alcohol or Drug Abuse, or any Addiction ❑ Yes ❑ No

g) Allergies, Asthma, Bronchitis, Respiratory Disorder, Shortness of Breath or Sleep Apnea ❑ Yes ❑ No

h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) ❑ Yes ❑ No

i) Arthritis, Rheumatism or Rheumatoid Arthritis ❑ Yes ❑ No

j) Cancer, Tumour, Cyst, Polyp or any Growth ❑ Yes ❑ No

k) Skin Disorder ❑ Yes ❑ No

l) Breast Disorder, Menopause, Reproductive Disorder, Infertility or Assisted Conception ❑ Yes ❑ No

m) Bladder, Kidney or Prostate Disorder or other Genitourinary Disorder ❑ Yes ❑ No

n) Headaches or Migraines ❑ Yes ❑ No

o) Diabetes, Endocrine Disorder, Pituitary or Thyroid Disorder or Lupus ❑ Yes ❑ No

p) Eye or Ear Disorder ❑ Yes ❑ No

q) Any other Complaint, Condition, Disease or Disorder ❑ Yes ❑ No

Please specify: _____

2. Have you, your co-applicant or any listed dependant(s) ever been treated for, hospitalized or had any known Physical Impairments, Congenital Abnormality, Medical Condition, Injury, Disease or Disorder **not stated above**? ❑ 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**, or are awaiting any tests or test results? ❑ Yes ❑ No

4. Have you, your co-applicant or any listed dependant(s) ever been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years? ❑ Yes ❑ No

5. If any "Yes" answers to questions 1 to 4 of Section D, please give explanation below:

Question No.	Name of Individual	Illness/Condition/Diagnosis	Date Diagnosed	Duration	Name and Telephone Number of Qualified Health Care Practitioner and/or Hospital Providing Treatment	Current Status of Condition

6. Are you, your co-applicant or any listed dependant(s) currently using or expecting to use in the next 3 months, or have you discontinued use of in the last 3 months any drug, medication, serum or other treatment? ❑ Yes ❑ No

If "Yes", provide details below:

Name of Individual	Name of the Drug/Medication/Serum/Treatment	Condition Being Treated	Strength and Daily Dosage of the Drug/Medication/Serum	Length of Time on This Drug/ Medication/Serum/Treatment

7. Are you, your co-applicant or any listed dependant(s) pregnant? ❑ Yes ❑ No

If "Yes", Name _____ Due Date _____ (DD/MMM/YYYY)

Notice on Privacy and Confidentiality

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. 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.

Applicant's Authorization and Declaration • All Applicants Must Complete This Section

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 or its reinsurers for the purpose of this application, any 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 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. Manulife 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 Manulife's Notice on Privacy and Confidentiality. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. I/We hereby designate the individual(s) named as beneficiary(ies) to receive any Accidental Death and Dismemberment proceeds payable. A photocopy of this signed authorization shall be as valid as the original.

Signed at (City, Province)	Signature of Primary Applicant	Dated (DD/MMM/YYYY)
Signed at (City, Province)	Signature of Co-Applicant	Dated (DD/MMM/YYYY)

Advisor's Report • For Advisor/Agent Use Only

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last)	Agent ID	Signature
	SB000	✖

Please send the completed application to:

Regular Mail or Courier:
Special Benefits Insurance Services
7th Fl - 366 Bay St
Toronto ON M5H 4B2

Fax
(1) 416-601-0308

Note: If you are contracted through a MGA/National Account firm, please forward the completed application to their office.

The Association Health & Dental Plan is offered through The Manufacturers Life Insurance Company (Manulife).