



**Flexcare® Application**

**All applicants must complete Parts A, B, C, D and E**  
**All applicants must complete and sign the**  
**Applicant's Authorization and Declaration**

ZZZ

Advisor ID:	SB000
Advisor Name:	Special Benefits Insurance Services
Advisor E-mail:	general@sbis.ca



AIR MILES® Collector #: 8

**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 \_\_\_\_\_ 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 Email \_\_\_\_\_ Co-Applicant's Email \_\_\_\_\_

If additional information is required, how may we contact you?  Home  Office  Email 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/MM/YYYY)

Group Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Date Benefits Ended \_\_\_\_\_ (DD/MM/YYYY)

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):

I hereby 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.

**Applicant's Beneficiary**

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

% of Benefit \_\_\_\_\_

**Co-Applicant's Beneficiary**

Name \_\_\_\_\_

Relationship to Co-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 \_\_\_\_\_ Name of Trustee \_\_\_\_\_

Relationship to Beneficiary \_\_\_\_\_ Relationship to Beneficiary \_\_\_\_\_

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**Part B • Plan Choice**

Remember: Your Plan Choice applies to all family members.

I/We apply for:

**CORE PLANS**

- DrugPlus™ Basic
- DrugPlus Enhanced
- DentalPlus™ Basic†
- DentalPlus Enhanced†
- ComboPlus™ Starter†
- ComboPlus Basic
- ComboPlus Enhanced

**ADD-ONS**

Available only with a Core plan

- Travel +8 days†
- Travel +21 days†
- Accidental Death & Dismemberment Enhanced†
- Hospital Basic
- Hospital Enhanced
- Catastrophic Coverage (\$4,500 threshold)
- Catastrophic Coverage (\$10,200 threshold)
- Vision Enhanced† (Not available with ComboPlus Starter)

**STAND-ALONES**

Available without a Core plan

- Hospital Basic
- Hospital Enhanced
- Catastrophic Coverage (\$4,500 threshold)
- Catastrophic Coverage (\$10,200 threshold)

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

**Part C • Individuals to be Covered**

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

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

**Part D • 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 E.**

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 E.**

Option #3  Direct Billing (Excludes initial 2 months' payment)

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



## Flexcare Medical Questionnaire

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**

### Section A • Treating Qualified Health Care Practitioner

**Must be completed in full for all plans except DentalPlus and ComboPlus Starter.**

Name and Telephone Number of Present Physician or Qualified Health Care Practitioner (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: \_\_\_\_\_

Date and Reason for Consultation: \_\_\_\_\_

To which individual applying for coverage does this apply? \_\_\_\_\_

### Section B • Simplified Underwriting Questionnaire

**Must be completed in full for all plans except DentalPlus, ComboPlus Starter and Catastrophic Coverage.**

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 a cold or flu.)  Yes  No

If any questions in Section B are answered "Yes", please complete section C below in full.

If applying for Catastrophic Coverage, please complete sections C and D below.

### Section C • Medical Declaration

**Must be completed in full for all plans except DentalPlus and ComboPlus Starter.**

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)

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>a) High Blood Pressure, High Cholesterol or any Circulatory or Blood Disorder <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>b) Heart or Blood Vessel Disorder, Heart Murmur, Chest Pain, Angina, Stroke or Transient Ischemic Attack (TIA) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>c) Back, Neck, Disc, Hip or Knee Pain or Disorder, Fibromyalgia, Osteoporosis, Osteopenia, Chronic Pain, Paralysis, Weakness or Numbness, or any other Musculoskeletal Disorder <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>d) Digestive System Disorder, Crohn's Disease, Ulcerative Colitis, Liver Disease or Disorder including Hepatitis or Hepatitis Carrier State <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>e) Mental, Nervous, Emotional or Neurological Disorder including Depression, Anxiety, Attention Deficit Disorder or Stress <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>f) Alcohol or Drug Abuse, or any Addiction <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>g) Allergies, Asthma, Bronchitis, Respiratory Disorder, Shortness of Breath or Sleep Apnea <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> </ol> | <ol style="list-style-type: none"> <li>i) Arthritis, Rheumatism or Rheumatoid Arthritis <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>j) Cancer, Tumour, Cyst, Polyp or any Growth <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>k) Skin Disorder <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>l) Breast Disorder, Menopause, Reproductive Disorder, Infertility or Assisted Conception <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>m) Bladder, Kidney or Prostate Disorder or other Genitourinary Disorder <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>n) Headaches or Migraines <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>o) Diabetes, Endocrine Disorder, Pituitary or Thyroid Disorder or Lupus <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>p) Eye or Ear Disorder <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>q) Any other Complaint, Condition, Disease or Disorder <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br/>Please specify: _____</li> </ol> |
|---|---|

Continued on page 5

## Flexcare Medical Questionnaire

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

### Section C • Medical Declaration (continued)

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 C, please give explanation below:

Question No.	Name of Individual	Illness/Condition/Diagnosis	Date Diagnosed	Duration	Name and Address 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 in the last 3 months of 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 of pregnant individual \_\_\_\_\_ Due Date \_\_\_\_\_ (DD/MM/YYYY)

### Section D • Catastrophic Medical Questionnaire

**Must also complete Sections A and C when applying for Catastrophic Coverage**

(Available either as an Add-On or Stand-Alone coverage)

1. Have your, your co-applicant's or any listed dependant's natural parents, brother(s) or sister(s), either living or dead, ever suffered from any of the following conditions: Heart Disease, Stroke, Cancer (specify type), Diabetes, Kidney Disease, Mental Illness, Alcoholism, Huntington's Chorea, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's or any other hereditary disease? If "Yes", please complete the section below.  Yes  No

Name of Individual	Relationship to Proposed Insured	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death

2. Have you, your co-applicant or any listed dependant(s) participated in the last 3 years or expect to participate in any activities of a hazardous nature including but not limited to: Motorized Vehicle Racing, Skin or Scuba Diving, Sky Diving, Mountain Climbing, Hang-Gliding, or any other hazardous sports or activities?  Yes  No  
If "Yes", please indicate the name of the avocation(s)/sport(s) and person(s) to whom it applies: \_\_\_\_\_
3. Do you, your co-applicant or any listed dependant(s) intend to fly other than as a passenger on a commercial airline, or have flown other than as a passenger on a commercial airline within the past 3 years?  Yes  No  
If "Yes", please indicate the name of the person(s) to whom this applies: \_\_\_\_\_
4. Have you, your co-applicant or any listed dependant(s) in the last 3 years had your driver's licence suspended, revoked or had 3 or more moving violations?  Yes  No  
If "Yes", please provide the name of the person(s) to whom this applies: \_\_\_\_\_  
Driver's Licence Number(s) \_\_\_\_\_

**If any questions above are answered "Yes", a supplemental questionnaire will be sent to you for completion.**

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

## 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 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.

### Notice on Information Provided to the AIR MILES® Reward Program

When you or your family member apply for insurance, Manulife may disclose to the AIR MILES® Reward Program your AIR MILES Collector Account number in order to administer the AIR MILES Reward Program, including the management of Collector accounts and to accurately record and update reward mile balances.

The AIR MILES Reward Program makes information about its privacy policies and practices readily available to individuals and its Collectors through written materials, its website ([www.airmiles.ca](http://www.airmiles.ca)) and other electronic means, its Interactive Voice Response system, and its Customer Care Centre. In addition, copies of the AIR MILES Privacy Pledge are available to individuals and Collectors upon request.

The AIR MILES Reward Program does not give, rent or sell Collector lists to any organization or individual other than its Affiliated Businesses, Sponsors, Suppliers and companies contracted to process and manage Collector transactions, redemption requests, research, analysis and communications and in all cases, only to fulfill the specified purposes. AIR MILES Collectors can opt out of receiving marketing and promotional communications in electronic, printed or verbal format, other than Collector Summaries, by writing to the AIR MILES Reward Program at AIR MILES, Customer Care, PO Box 602, Station A, Scarborough, Ontario, M1K 5K7 or by email to [privacyoffice@airmiles.ca](mailto:privacyoffice@airmiles.ca). The decision to opt out of additional communications does not affect your ability to collect or redeem reward miles in the AIR MILES Reward Program.

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

### This plan is underwritten by The Manufacturers Life Insurance Company.

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 and Notice on Information provided to the AIR MILES® Reward Program. 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	Signature of Primary Applicant	Dated
		(DD/MM/YYYY)
Signed at	Signature of Co-Applicant	Dated
		(DD/MM/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)	Advisor code <b>SB000</b>	Signature <b>x</b>
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Please send the completed application to:

<b>Regular Mail or Courier:</b> Special Benefits Insurance Services 7th Fl - 366 Bay St Toronto ON M5H 4B2	<b>Fax:</b> (1) 416-601-0308
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Note: if you are contracted through a MGA/National Account firm, please forward the completed application to their office.

Flexicare® is offered through **The Manufacturers Life Insurance Company (Manulife)**.

Plans underwritten by The Manufacturers Life Insurance Company. Manulife and the Block Design are trademarks of The Manufacturers Life Insurance Company and are used by it, and by its affiliates under licence. ©/™ Trademarks of AIR MILES International Trading B.V. Used under license by LoyaltyOne Inc. and Manulife. ™/© Trademarks held by The Manufacturers Life Insurance Company. © 2017 The Manufacturers Life Insurance Company. All rights reserved. Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

Accessible formats and communication supports are available upon request. Visit [Manulife.com/accessibility](http://Manulife.com/accessibility) for more information.