

Group Benefits Evidence of Insurability for Comprehensive Optional Critical Illness Insurance

INSTRUCTIONS - Please print all answers

If required, retain a photocopy for your files.

1 a) Plan member information

Required if applying for member or spousal coverage

Plan contract number(s)	Division number	Plan member certificate number	
Plan sponsor/employer name			
Plan member name (last, first and middle initial)			
Sex <input type="radio"/> Male <input type="radio"/> Female	Date of birth (dd/mmm/yyyy)	Home phone number ()	Business phone number ()
Plan member's address (street number, street and apartment)			
City		Province	Postal code
Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? <input type="radio"/> Yes <input type="radio"/> No			

1 b) Basic medical information

Complete this section when you need to provide evidence of insurability as part of your application.

Height _____ m _____ cm _____ ft _____ in	Weight <input type="radio"/> kg <input type="radio"/> lb	Any weight change greater than 10 pounds in the last 12 months? <input type="radio"/> No <input type="radio"/> Yes Gain/loss _____ <input type="radio"/> kg <input type="radio"/> lb Reason: _____
Name of personal physician (last, first and middle initial)		Physician's phone number ()
Date of last visit (dd/mmm/yyyy)	Reason	
Address of personal physician (street number, street and suite)		
City		Province Postal code

2 a) Spousal information

Only required if applying for spousal coverage

Spouse's name (last, first and middle initial)	Sex <input type="radio"/> Male <input type="radio"/> Female	Date of birth (dd/mmm/yyyy)
Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? <input type="radio"/> Yes <input type="radio"/> No		

2 b) Basic medical information

Complete this section when you need to provide evidence of insurability for your spouse as part of the application.

Height _____ m _____ cm _____ ft _____ in	Weight <input type="radio"/> kg <input type="radio"/> lb	Any weight change greater than 10 pounds in the last 12 months? <input type="radio"/> No <input type="radio"/> Yes Gain/loss _____ <input type="radio"/> kg <input type="radio"/> lb Reason: _____
Name of personal physician (last, first and middle initial)		Physician's phone number ()
Date of last visit (dd/mmm/yyyy)	Reason	
Address of personal physician (street number, street and suite)		
City		Province Postal code

3 Medical questionnaire

The following questions should be answered by each individual applying for coverage that needs to provide evidence of insurability as part of your application. Check your rate sheet for instructions. If more space is needed, use another form or sheet of paper (both must be signed and dated).

			Plan member	Spouse
A. Have you ever had an application for any insurance that was declined, postponed or rated in any way? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)	Reason		
B. Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment, care or been advised to receive care or have further treatment for:				
1) AIDS, a positive HIV test or AIDS-related disease?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2) Diabetes?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3) Multiple sclerosis?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4) Organ transplant?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
5) Hepatitis or hepatitis carrier state, other than Hep A?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
6) Stroke or transient ischemic attack (TIA)?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
7) Alzheimer's disease or Parkinson's disease?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
8) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9) Motor neuron diseases, including but not limited to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
10) Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congestive heart failure, arrhythmia, peripheral vascular disease, or aneurysm?			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
11) Paralysis? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Is it trauma related?			
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Local or <input type="radio"/> General paralysis		
Details				
12) Chest pain? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)	Cause		
Diagnosis	Status			
Treatment				
13) Congenital heart disorder? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)	Cause		
Diagnosis	Status			
Treatment				
14) Heart murmur, shortness of breath, irregular heart beat, any disorder of the blood? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)	Cause		
Diagnosis	Status			
Treatment				
15) Lymph, glandular disorder, or thyroid disorder? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)			
Diagnosis	Status			
Treatment				

3 Medical questionnaire (continued)

Plan member **Spouse**

16) Disorder of the eye or ear leading to blindness or deafness? If answered yes, please provide details.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Name of person			Date (dd/mmm/yyyy)						
Diagnosis			Status						
Treatment									
17) Alcohol or drug abuse? If answered yes, please provide details.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Name of person		Date (dd/mmm/yyyy) and duration							
Treatment and results									
18) Disorder of the brain or nervous system, neurological disorder, epilepsy, optic neuritis, blurred or double vision, memory loss, weakness, tremor, numbness or tingling, impaired balance, loss of consciousness? If answered yes, please provide details.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Name of person		Date of onset (dd/mmm/yyyy)		Date of last symptoms (dd/mmm/yyyy)					
Diagnosis			Status						
Treatment									
Name and address of doctor seen									
19) Cancer, leukemia, Hodgkin's disease or other malignancy?						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
20) Growths, cysts or tumour? If answered yes, please provide details.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Name of person		Date (dd/mmm/yyyy)		Type					
Location on body			Status <input type="radio"/> Benign <input type="radio"/> Malignant						
Treatment									
21) Dysplastic nevi or moles? If answered yes, please provide details.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Name of person		Date (dd/mmm/yyyy)		Type					
Location on body			Status <input type="radio"/> Benign <input type="radio"/> Malignant						
Treatment									
22) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs? If answered yes, please provide details.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Name of person		Date of onset (dd/mmm/yyyy)		Date of last symptoms (dd/mmm/yyyy)					
Diagnosis			Status						
Treatment									
Name and address of doctor seen									
C. 1) Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, chronic kidney disease, angina, stroke, multiple sclerosis, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60? If answered yes, please provide details in the chart below.						<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Member or spouse's family member	Name of family member	Relationship	Condition	Age at onset	Age at death (if applicable)				
<input type="radio"/> Member <input type="radio"/> Spouse									
<input type="radio"/> Member <input type="radio"/> Spouse									
<input type="radio"/> Member <input type="radio"/> Spouse									
<input type="radio"/> Member <input type="radio"/> Spouse									

3 Medical questionnaire (continued)

			Plan member	Spouse
2) If you have a family history of breast or ovarian cancer, have you had a breast exam, mammogram or other investigation? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)			
Results				
3) If you have a family history of colon cancer, have you had a colonoscopy? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)			
Results				
D. During the last 5 years, have you had any abnormal result of any of the following: EKG, stress EKG, echocardiograms, mammogram, Pap smear (exclude if 2 subsequent Pap smears have been normal), PSA, sigmoidoscopy, colonoscopy, biopsy? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Test type	Date (dd/mmm/yyyy)		
Test results		Status		
Treatment				
E. Other than for a common cold, osteoarthritis, bone fractures, have you had an abnormal result of any of the following: X-ray, CAT scan, or MRI? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Test type	Date (dd/mmm/yyyy)		
Test results		Status		
F. Have you ever had elevated blood pressure or cholesterol? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person	Date (dd/mmm/yyyy)			
Most recent results	Is it under control?			
Treatment				
G. Are you aware of any symptoms or complaints for which you have not sought treatment or advice, or are you awaiting any tests or test results? If answered yes, please provide details.			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of person				
Details				

4 Certification and authorization

I certify that I (being the plan member, spouse or dependant 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 Financial ("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, 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/groupbenefits, or from my Plan Sponsor.

Plan member's 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.

5 Mailing instructions

Please send the completed form to:

**Group Medical Underwriting
 Manulife Financial
 PO BOX 2026
 HALIFAX NS B3J 2Z1**