Manulife Financial

For your future™

Group Benefits
Application for Insurance and Evidence of Insurability for Self-Administered Plans

INSTRUCTIONS - Please print all answers

1. *Please consult your plan administrator for type of coverage available under your plan.*
2. *Please ensure that ALL SECTIONS are completed.*
   *Section 1 - Plan sponsor information - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR.***
   Sections 2, 3, 4 and 5 - Plan member information - To be completed by plan member and submitted to Manulife Financial.
3. ***If required, retain a photocopy for your files.***

1 Plan sponsor information

Plan contract number	Division number	Plan member certificate number	Class	**Annual earnings**
903057				**$**

Plan sponsor: **Nova Scotia Association of Health Organizations**

Eligibility date (dd/mmm/yyyy)

Plan administrator name | Phone number ( ) | Email address

Plan member name (last, first and middle initial) | Date of birth (dd/mmm/yyyy)

Language preference/Langue préférée: ◯ English/Anglais ◯ French/Français | Sex: ◯ Male ◯ Female | Province of residence

Coverage being applied for:

◯ LTD/OPT LTD

Plan member's present amount of coverage $ _____

Additional amount requested $ _____

Total amount requested $ _____

◯ LTD Option: From _____ To _____ Life Option: From _____ To _____

Signature of plan administrator | Date signed (dd/mmm/yyyy)

2 Plan member statement

Plan member name (last, first and middle initial) | Occupation

Sex: ◯ Male ◯ Female | Date of birth (dd/mmm/yyyy) | Home phone number ( ) | Business phone number ( )

Plan member address (number, street, apt.)

City | Province | Postal code

Height: _____ m _____ cm / _____ ft _____ in | Weight: ◯ kg ◯ lb | Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

Have you lost or gained more than 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)

Address of personal physician (number, street, suite) | Physician's phone number ( )

City | Province | Postal code

3 Medical questions for proposed insured

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

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
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◯ No
2. Have you (a) ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◯ No
(b) ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◯ No
(c) been absent from work for medical reasons during the last 5 years?	◯ Yes ◯ No
(d) currently received any treatment/medications?	◯ Yes ◯ No
(e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◯ No
(f) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)?	◯ Yes ◯ No
3. Have you ever consulted a physician, ever been treated for, or had any known identification of (a) chest pain, blood vessel disease, heart disorder, or heart attack or stroke?	◯ Yes ◯ No
(b) high blood pressure?	◯ Yes ◯ No
(c) allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◯ No
(d) glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◯ No
(e) epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinsons)?	◯ Yes ◯ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◯ No
(g) excessive use of alcohol or drugs?	◯ Yes ◯ No
(h) lung disorders?	◯ Yes ◯ No
(i) bowel, stomach or liver disorders?	◯ Yes ◯ No
(j) cancer?	◯ Yes ◯ No
(k) disorder of the kidney, urine or genital organs?	◯ Yes ◯ No
(l) arthritis, rheumatism or fibromyalgia?	◯ Yes ◯ No
(m) disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◯ No
(n) 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
(o) anemia, or other blood disorders?	◯ Yes ◯ No
4. 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

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	Details or name of condition	Date and duration	Medication/treatment and results (recovery or remaining effects)	Names and addresses of physicians and hospitals

4 Certification and authorization

I certify that I 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 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 name (please print)

Plan member signature

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