Manulife

Group Benefits
Application and Evidence of Insurability for Comprehensive Optional Critical Illness Insurance

INSTRUCTIONS – Please print all answers

1. Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box to indicate the type of coverage for which you are applying.
   ◯ *PLAN MEMBER ONLY* ◯ *PLAN MEMBER AND SPOUSE* ◯ *PLAN MEMBER, SPOUSE AND CHILDREN* ◯ *SPOUSE AND/OR CHILDREN*
   ◯ *PLAN MEMBER AND CHILDREN*
2. Section 1 - Plan sponsor information – ***TO BE COMPLETED FIRST BY THE PLAN ADMINISTRATOR***
   Sections 2 a), 2 b), 3 a), 3 b), 4 and 5 - Plan member/spouse information – Complete applicable sections and submit to Manulife.
3. ***If required, retain a photocopy for your files.***

1 Plan sponsor information

Plan contract number(s)	Division number	Plan member certificate number
87916		

Plan sponsor name	Class

◯ **Late entrant plan member basic critical illness**

Plan member optional critical illness amount
Available in multiples of $5,000 with a minimum $10,000 up to $150,000

Plan member's present amount of critical illness	Additional amount requested	Total amount requested
$ _____	$ _____	$ _____

Spousal critical illness amount
Available in multiples of $5,000 with a minimum $10,000 up to $150,000

Spouse's present amount of critical illness	Additional amount requested	Total amount requested
$ _____	$ _____	$ _____

◯ **Child critical illness**

Plan administrator name	Date signed (dd/mmm/yyyy)

Phone number	Ext.	Email address
( )		

2 a) Plan member information

Required if applying for member or spousal coverage.

Plan member name (last, first and middle initial)

Sex*	Date of birth (dd/mmm/yyyy)
◯ Male ◯ Female ◯ Non-binary	

*Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Home phone number	Business phone number Ext.

Plan member's address (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? ◯ Yes ◯ No

2 b) Basic medical information

Complete this section when you need to provide evidence of insurability as part of your application. Check your rate sheet for instructions.

Height
_____ m _____ cm
_____ ft _____ in

Weight
◯ kg
◯ lb

Any weight change greater than 10 pounds (4.5 kg) in the last 12 months?
◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb
Reason: _____

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

Physician's phone number Ext.

Date of last consult (dd/mmm/yyyy)

Reason

Address of personal physician (number, street and suite)

City

Province

Postal code

3 a) Spousal information

Only required if applying for spousal coverage.

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

Sex*
◯ Male ◯ Female ◯ Non-binary

Date of birth (dd/mmm/yyyy)

*Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

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 b) Basic medical information

Complete this section when you need to provide evidence of insurability as part of your application. Check your rate sheet for instructions.

Height
_____ m _____ cm
_____ ft _____ in

Weight
◯ kg
◯ lb

Any weight change greater than 10 pounds (4.5 kg) in the last 12 months?
◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb
Reason: _____

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

Physician's phone number Ext.

Date of last consult (dd/mmm/yyyy)

Reason

Address of personal physician (number, street and suite)

City

Province

Postal code

4 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.	◯ Yes ◯ No	◯ Yes ◯ 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?	◯ Yes ◯ No	◯ Yes ◯ No
2) Diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
3) Multiple sclerosis?	◯ Yes ◯ No	◯ Yes ◯ No
4) Organ transplant?	◯ Yes ◯ No	◯ Yes ◯ No
5) Hepatitis or hepatitis carrier state, other than Hep A?	◯ Yes ◯ No	◯ Yes ◯ No
6) Stroke or transient ischemic attack (TIA)?	◯ Yes ◯ No	◯ Yes ◯ No
7) Alzheimer's disease or Parkinson's disease?	◯ Yes ◯ No	◯ Yes ◯ No
8) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?	◯ Yes ◯ No	◯ Yes ◯ No
9) Motor neuron diseases, including but not limited to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)?	◯ Yes ◯ No	◯ Yes ◯ 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?	◯ Yes ◯ No	◯ Yes ◯ No

4 Medical questionnaire (continued)

	Plan member	Spouse
11) Paralysis? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Is it trauma related? ◯ Yes ◯ No / ◯ Local or ◯ General paralysis		
Details		
12) Chest pain? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Cause		
Diagnosis / Status		
Treatment		
13) Congenital heart disorder? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
16) Disorder of the eye or ear leading to blindness or deafness? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
17) Alcohol or drug abuse? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ 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		

4 Medical questionnaire (continued)

	Plan member	Spouse
19) Cancer, leukemia, Hodgkin's disease or other malignancy? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
20) Growths, cysts or tumour? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
21) Dysplastic nevi or moles? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
22) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ 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, diabetes (2 or more family members prior to age 50), chronic kidney disease, angina, stroke, multiple sclerosis, Huntington's disease, 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.	◯ Yes ◯ No	◯ Yes ◯ No

Plan member or spouse's family member	Relationship	Condition	Age at onset	Age at death (if applicable)
◯ Plan member ◯ Spouse				
◯ Plan member ◯ Spouse				
◯ Plan member ◯ Spouse				
◯ 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.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Results		

4 Medical questionnaire (continued)

	Plan member	Spouse
3) If you have a family history of colon cancer, have you had a colonoscopy? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ 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.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person		
Details		

5 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 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/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.

6 Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife
PO BOX 1900, STATION C
KITCHENER ON N2G 4R4

Phone: 1-800-268-6195 or 519-747-7000

Fax: 519-883-5702

PRINT