HEALTH PLAN APPLICATION – PAGE 1
***All applicants must complete parts A, B, C, D**
***All applicants must sign and complete Page 4, Applicant's Declaration**

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AIR MILES # : 8 | | | | | | | | | | | | WSF

Agent ID	For Manulife Financial Use Only
ON1684	Keyed _____ Approval _____

PART A • GENERAL INFORMATION

Applicant's Last Name _____ First Name _____ Initial ____ Government Health Card Number | | | | | | | | | | |

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

City or Town _____ Province _____ Postal Code _____ Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Other

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

Applicant's Fax ( ) _____ Co-Applicant's Fax ( ) _____

Applicant's Email _____ Co-Applicant's Email _____

If additional information is required during regular business hours, how may we contact you? ☐ Home Tel. ☐ Office Tel. ☐ Email.

Are you now covered or did you have previous health insurance coverage with Manulife Financial or any other insurance company? ☐ Yes ☐ No If "Yes", please indicate:

Plan Number _____ ID Number _____ Insurance Company _____ Date benefits ended? (dd/mm/yyyy) _____

Plan Number _____ ID Number _____ Insurance Company _____ Date benefits ended? (dd/mm/yyyy) _____

Is the application intended to replace your current coverage? ☐ Yes ☐ No

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

Name _____ Relationship to Applicant _____

Signature of Applicant _____ Date (dd/mm/yyyy) _____

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed.

Name of Trustee _____ Relationship to Applicant _____

Signature of Applicant _____ Date (dd/mm/yyyy) _____

PART B • PLAN CHOICE

Remember: Your Plan Choice applies to all family members, except Lifeline®‡

I/We apply for:

CORE PLANS
- ☐ DentalPlus™ *Basic**
- ☐ DentalPlus™ *Enhanced**
- ☐ DrugPlus™ *Basic*
- ☐ DrugPlus™ *Enhanced*
- ☐ ComboPlus™ *Starter**
- ☐ ComboPlus™ *Basic*
- ☐ ComboPlus™ *Enhanced*

ADD-ONS Available only with a Core plan
- ☐ Travel *+8 days** (Not available with ComboPlus *Starter*)
- ☐ Travel *+21 days** (Not available with ComboPlus *Starter*)
- ☐ Accidental Death & Dismemberment *Enhanced**
- ☐ Extended Health Care (EHC) *Enhanced*
- ☐ Hospital *Basic*
- ☐ Hospital *Enhanced*
- ☐ Hospital *Cash*
- ☐ Catastrophic Coverage
- ☐ Vision *Enhanced** (Not available with ComboPlus *Starter*)

STAND-ALONES Available without a Core plan
- ☐ Extended Health Care (EHC) *Basic*
- ☐ Extended Health Care (EHC) *Enhanced*
- ☐ Hospital *Basic*
- ☐ Hospital *Enhanced*
- ☐ Hospital *Cash*
- ☐ Catastrophic Coverage

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

For Lifeline®‡ Personal Response Service, call 1-877-COVER ME® (1-877-268-3763) and request a Lifeline application.

PART C • INDIVIDUALS TO BE COVERED

FIRST NAME / LAST NAME	HEALTH CARD NO.	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
		00								
APPLICANT		01								
CO-APPLICANT		02								
DEPENDANT CHILD		02								
DEPENDANT CHILD		02								
DEPENDANT CHILD		02								
DEPENDANT CHILD										

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

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PART D • BILLING OPTIONS

Initial Payment: I hereby authorize Manulife Financial to debit the initial 2 months premium, $_____, from my/our:

☐ Financial Services Account ☐ Credit Card Account

Subsequent Payments: Will be made by:

☐ **Pre-Authorized Payment Plan (PAP) from My Financial Institution (Please also complete PART E below)**

PAP Billing Frequency: ☐ Monthly ☐ Semi-annually (2% Discount) ☐ Annually (4% Discount)

☐ **Credit Card (Please also complete PART E below)**

☐ Visa ☐ MasterCard ☐ Amex Account # _____ Expiry Date (mm/yyyy) _____

Cardholder: _____ Signature of Cardholder: _____
(if other than Applicant or Co-Applicant)

Credit Card Billing Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

☐ **Direct Billing**

Direct Billing Frequency: ☐ Semi-annually (2% Discount) ☐ Annually (4% Discount)

Important: For verification purposes we require a VOID cheque if a payment is being withdrawn from your financial institution.

Please Note: Billing frequency discounts are not available for Credit Card payment options.

Manulife Financial 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 NSF fee will be charged for all NSF transactions.

PART E • FINANCIAL INSTITUTION

Name of account holder(s) if different from Applicant _____

Financial Institution _____

Address _____ City/Town _____

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ Current ☐ Direct Deposit Account ☐ Other

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. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

For Pre-Authorized Payment and Credit Card billing options: I/We hereby authorize Manulife Financial 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 Financial or by me/us through written notice.

Signature of account holder: _____ Second signature if joint account: _____

SECTION A • TREATING QUALIFIED HEALTH CARE PRACTITIONER

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

Name and Address 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	Applicant	Co-Applicant	Dependant(s)
Name of Primary Health Care Provider:			
Address of Primary Health Care Provider:			
Last Consultation Date:			
Reason:			
Diagnosis made:			
Treatment given:			

Name and Address of any other Qualified Health Care Practitioner consulted: _____

Reason for Consultation: _____

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

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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.

***All applicants must sign and complete Page 4, Applicant's Declaration**

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SECTION B • PREFERRED UNDERWRITING QUESTIONNAIRE

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

These questions are intended for streamlining applicants.

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

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 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 major medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? ☐ Yes ☐ No

Note: Additional medical information may be required to underwrite your application.

If any questions above are answered "Yes", please complete sections C and D below.

SECTION C • MEDICAL CONDITIONS

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

1. Have you, your co-applicant or any listed dependant 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, Stroke, T.I.A. or Chest Pain ☐ Yes ☐ No
   b) Heart, High Cholesterol or Circulatory Disorder, Dizziness, Fainting or Blood Disorder ☐ Yes ☐ No
   c) Back, Joint or any Musculoskeletal Pain or Disorder ☐ Yes ☐ No
   d) Digestive System Disorder, Liver Disease/ Disorder including Hepatitis ☐ Yes ☐ No
   e) Nervous, Mental, Emotional or Stress Disorder ☐ Yes ☐ No
   f) Alcohol/Drug Abuse ☐ Yes ☐ No
   g) Asthma/Allergies/Respiratory Disorder or Shortness of Breath ☐ Yes ☐ No
   h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) ☐ Yes ☐ No
   i) Arthritis/Rheumatism ☐ Yes ☐ No
   j) Cancer, Tumor or any Growth ☐ Yes ☐ No
   k) Skin Disorder ☐ Yes ☐ No
   l) Infertility/Reproductive Disorder/Menopause ☐ Yes ☐ No
   m) Bladder/Kidney Disorder or other Genitourinary Disorder ☐ Yes ☐ No
   n) Headaches/Migraines ☐ Yes ☐ No
   o) Diabetes/Endocrine Disorder ☐ Yes ☐ No
   p) Eye or Ear Disorder ☐ Yes ☐ No
   q) Other Condition/Disease/Disorder ☐ Yes ☐ No
   Please specify _____

2. Have you, your co-applicant or any listed dependant ever been treated for, hospitalized or had any known Physical Impairments, Congenital Abnormality, Medical Condition, Disease or Disorder not stated above? Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant Child ☐ Yes ☐ No
3. Have you, your co-applicant or any listed dependant ever been advised to have an investigation, hospitalization or surgery which has not been completed? Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant Child ☐ Yes ☐ No
4. If answer is "Yes" to any question in Section C, give explanation below:

Question No.	Proposed insured with condition	Name of illness / condition	Date Diagnosed	Duration	Name and Address of Qualified Health Care Practitioner and/or hospital providing treatment	Results of treatment and extent of recovery

SECTION D • MEDICATIONS AND TREATMENTS

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

5. Are you, your co-applicant or any listed dependant currently using or expect to use in the next 3 months any drug, medication, serum or other treatment? ☐ Yes ☐ No
   If "Yes", provide details below:

Proposed insured	Name of the drug / medication / serum / treatment	Condition being treated	Strength and daily dosage of the drug / medication / serum	Monthly cost	Length of time on this drug / medication / serum / treatment

6. Are you, your co-applicant or any listed dependant pregnant? ☐ Yes ☐ No If "Yes", Name _____ Due Date (dd/mm/yyyy)

Note: Additional medical information may be required to underwrite your application.

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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.

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SECTION E • CATASTROPHIC MEDICAL QUESTIONNAIRE

Must also complete Sections A, B, C, D when applying for Catastrophic Coverage (Available either as an Add-On or Stand-Alone coverage)

1. Have you, your co-applicant or any listed dependant, natural parents, brother(s), 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? ☐ Yes ☐ No

   If "Yes", please complete the section below.

NAME OF PROPOSED INSURED	RELATIONSHIP TO PROPOSED INSURED	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH

2. **Avocation and Sports**

   Have you, your co-applicant or any listed dependant 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 to whom it applies: _____
   A supplemental questionnaire will be sent to you for completion.

3. Do you, your co-applicant or any listed dependant, 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 to whom this applies: _____
   A supplemental questionnaire will be sent to you for completion.

4. **Driving Record**

   Have you, your co-applicant or any listed dependant in the last 3 years had your drivers licence suspended, revoked or had 3 or more moving violations? ☐ Yes ☐ No

   If "Yes", please provide:

   Name: _____ Drivers Licence Number: _____

   Details: _____

   _____

APPLICANT'S DECLARATION • ALL APPLICANTS MUST COMPLETE THIS SECTION

This Plan is underwritten by The Manufacturers Life Insurance Company.

☐ Check here if you do not wish to receive further information and material on Manulife Financial's products.

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 Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial 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 Financial 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 the Notice on Privacy and Confidentiality and the 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. A photocopy of this signed authorization shall be as valid as the original.

Signature of Applicant _____ Signature of Co-Applicant _____ Dated (dd/mm/yyyy) _____

Flexcare is offered through Manulife Financial (The Manufacturers Life Insurance Company).

Manulife Financial