

HEALTH & DENTAL PLAN APPLICATION

For Manulife Financial Use Only.
 Keyed _____
 Approval _____

WSE

Agent ID
BC1190

Logo ID

***All applicants must complete parts A, B, C, D and E**

***All applicants must complete and sign Applicant's Declaration on back page.**

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

Part A • General Information

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

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

City or Town _____ Postal Code _____ Occupation _____

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 Office Email

Are you now covered or did you have previous group 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 this application intended to replace your current coverage? Yes No

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):

Applicant's Beneficiary: _____ Name _____ Relationship to Applicant _____ Signature of Applicant _____ Date _____ (DD/MM/YYYY)	Co-Applicant's Beneficiary: _____ Name _____ Relationship to Co-Applicant _____ Signature of Co-Applicant _____ Date _____ (DD/MM/YYYY)
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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)	Name of Trustee _____ Relationship to Co-Applicant _____ Signature of Co-Applicant _____ Date _____ (DD/MM/YYYY)
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Part B • Plan Choice

I/We apply for the following Health Plan:

- Base Health & Dental Plan* Bronze Health & Dental Plan Silver Health & Dental Plan Gold Health & Dental Plan
 Base Dental Plan* Bronze Dental Plan* Silver Dental Plan* Gold Dental Plan*

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

Part C • Individuals to be Covered

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

Part D • Billing Options

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

Financial Institution Account Credit Card Account

Subsequent Payments: Will be made by:

Pre-Authorized Collection Plan (PAC) From My Financial Institution Account (Please also complete PART E below)

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

Credit Card (Please read and sign PART E below): Visa MasterCard Amex Account # _____ Expiry Date _____
(MM/YY)

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

Credit Card Billing Frequency: Monthly Semi-annually Annually

Direct Billing: 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 Account.

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 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 prior written notice is given to Manulife Financial by the account holder requesting cancellation.

For Pre-Authorized Collection 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

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 approval of this application.

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

If applying for the Bronze, Silver or Gold Health & Dental Plan you must complete Section A and B, and complete/sign the Applicant's Declaration. Sections C and D must be completed if any questions in Section B are answered "yes". If applying for Base Health & Dental, Base Dental, Bronze Dental, Silver Dental or Gold Dental Plan applicants must complete and sign the Applicant's Declaration only.

Section A • Treating Qualified Health Care Practitioner

Must be completed for all plans except Base Health & Dental, Base Dental, Bronze Dental, Silver Dental and Gold Dental.

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	For the Applicant	For the Co-Applicant	For the 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: _____

Name of person who consulted other Practitioner: _____

Date and reason for consultation: _____

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

Section B • Simplified Questionnaire

Must be completed for all plans except Base Health & Dental, Base Dental, Bronze Dental, Silver Dental and Gold Dental.

Have you, your Co-Applicant or any listed dependant:

- | | |
|---|---|
| <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. a) Been advised to use a medication or treatment for a chronic and/or recurring medical condition; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>b) Used any medication or treatment for 20 or more days within the past year; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Expect to use any medication or treatment within the next 3 months. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="font-size: small;">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</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="font-size: small;">Note: Additional medical information may be required to underwrite your application.</p> |
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If any questions above are answered "Yes", please complete sections C and D below.

Section C • Medical Conditions

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: Check (✓) Yes or No to all questions.

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