

ASSOCIATION GROUP INSURANCE

COMPLETING AND RETURNING THIS APPLICATION FORM COULD BE THE BEST THING YOU'VE EVER DONE TO HELP SECURE YOUR FINANCIAL FUTURE AND THE FUTURE OF YOUR FAMILY. FOR THE AFFORDABLE PROTECTION THAT YOUR PROFESSIONAL ASSOCIATION GROUP PLAN CAN PROVIDE, PLEASE REPLY TODAY!

Members and Spouses must be between 18 and less than 61 years of age. Eligible children are those unmarried, dependent on the member for support and over 14 days of age and under 21 or over 20 but less than 25 years of age if attending school or university full time. All applicants must be residing in Canada.

MEMBER INFORMATION

Name First Last Male Female

Unit/Apt. # No./Street City

Province Postal Code Tel. Res. () () Bus. () ()

E-mail Date of Birth / / Day / Month / Year Country of Birth

Applicant is a member of: OR (specify in what capacity, in relation to the above Association/Society you are applying)

Occupation

SPOUSE INFORMATION (if applying for spouse coverage)

Name First Last Male Female

Date of Birth / / Day / Month / Year Country of Birth Occupation If self-employed, please describe nature of business and duties.

BENEFICIARY INFORMATION

Beneficiary on Member Coverage Relationship

In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

Beneficiary on Spousal Coverage Relationship

The Member is the beneficiary for any spouse coverage unless indicated otherwise above.
In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

BENEFITS APPLIED FOR AT THIS TIME (Do not include amounts already in force)

| | | | | |
|--|--|------------------------------------|------------------------|---------------------------|
| New Coverage <input type="checkbox"/> | Additional Coverage <input type="checkbox"/> | Certificate # <input type="text"/> | (if currently insured) | AMOUNT OF COVERAGE |
| Member Term Life Insurance Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/> | | | | = \$ <input type="text"/> |
| Indicate the amount you are applying for in \$25,000 increments. Minimum – \$50,000 | | | | |
| 10% rate reduction on \$200,000 or more | | | | = \$ <input type="text"/> |
| Spouse Term Life Insurance Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/> | | | | = \$ <input type="text"/> |
| Available only if you participate in the Member Term Life Plan. Minimum – \$50,000 | | | | |
| 10% rate reduction on \$200,000 or more | | | | = \$ <input type="text"/> |
| Child Term Life Insurance Available only if you participate in the Member Term Life Plan. Yes <input type="checkbox"/> | | | | = \$ <input type="text"/> |
| (One monthly premium of \$2.25 covers all your eligible children for \$10,000 of life coverage each.) | | | | |
| Member Personal Accident Insurance Available if you participate in the Member Term Life Plan. | | | | |
| MONTHLY PREMIUM: Up to \$100,000 <input type="checkbox"/> \$6 Up to \$150,000 <input type="checkbox"/> \$9 Up to \$200,000 <input type="checkbox"/> \$12 Up to \$250,000 <input type="checkbox"/> \$15 <input type="checkbox"/> \$ <input type="text"/> other amount | | | | = \$ <input type="text"/> |
| Spouse Personal Accident Insurance Available if you participate in the Spouse Term Life Plan. | | | | |
| MONTHLY PREMIUM: Up to \$100,000 <input type="checkbox"/> \$6 Up to \$150,000 <input type="checkbox"/> \$9 Up to \$200,000 <input type="checkbox"/> \$12 Up to \$250,000 <input type="checkbox"/> \$15 <input type="checkbox"/> \$ <input type="text"/> other amount | | | | = \$ <input type="text"/> |
| Member Income Protection Insurance Choose a Benefit amount (\$100 - \$5,000 per month) Waiting period <input type="text"/> days. | | | | = \$ <input type="text"/> |
| Office Overhead Expense Insurance Choose a Benefit amount (\$100 - \$5,000 per month) Waiting period <input type="text"/> days. | | | | = \$ <input type="text"/> |

*Non-Smoker rates apply to people who have not smoked cigarettes in the past 12 months and who meet Manulife Financial's health standards.

All Applicants: This application is not valid unless the Underwriting Questionnaire section is properly completed and the application is signed.
Québec Residents: After completion, you may detach this section and send it directly to Manulife Financial in the enclosed business reply envelope.

UNDERWRITING QUESTIONNAIRE – PLEASE ANSWER ALL QUESTIONS

Member's Physician Name Tel. # Date last seen (D/M/Y)

Reason for Visit Result

Spouse's Physician Name Tel. # Date last seen (D/M/Y)

Reason for Visit Result

Member's Height Weight Spouse's Height Weight

| | | | |
|--|--|--|--|
| Has any individual proposed for coverage: | Member | Spouse | Child(ren) |
| 1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including carrier state), kidney disorder, urinary abnormality, unusual infection or immune system abnormality, or other illness not mentioned? . . . | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Used drugs for other than medical purposes, been treated for or advised to reduce alcohol or drug use or used marijuana in the past 7 years? . . . | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Ever had back, neck, hip or knee trouble or been treated for chronic pain or fibromyalgia, had X-rays of spine or joints or been hospitalized or disabled by any injuries? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Ever had any positive test, treatment for or exposure to HIV or AIDS? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

