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AIR MILES® Collector #: 8

Flexcare® Health and Dental Insurance Application for Quebec Residents

The Manufacturers Life Insurance Company

***All applicants must complete parts A, B, C, D**
***All applicants must complete and sign the Applicant's Declaration**

Part A – General Information

Primary Applicant's

Last Name _____

First Name _____ Initial _____

Address _____

_____

City _____

Province _____ Postal Code _____

Telephone (Res.) (_____) _____

Telephone (Bus.) (_____) _____

If additional information is required, how may we contact you?

☐ Home Telephone ☐ Office Telephone ☐ Email

Does each applicant have provincial/territorial health care coverage? *

☐ Yes ☐ No

*All applicants must have coverage under a provincial/territorial health care insurance plan in order to be eligible for this insurance product. If anyone on the application does not meet this requirement, please contact our Customer Service for more information.

Are you now covered or did you recently have employer group health insurance coverage? ☐ Yes ☐ No If "Yes", please indicate:

Applicant's Group Plan Number _____

Insurance Company _____

ID Number _____

Date benefits ended _____ DD / MM / YYYY

Co-Applicant's

Last Name _____

First Name _____ Initial _____

Telephone (Res.) (_____) _____

Telephone (Bus.) (_____) _____

If additional information is required, how may we contact you?

☐ Home Telephone ☐ Office Telephone ☐ Email

Are you now covered or did you recently have employer group health insurance coverage? ☐ Yes ☐ No

If "Yes", please indicate (if different than that of Primary Applicant)::

Co-Applicant's Group Plan Number _____

Insurance Company _____

ID Number _____

Date benefits ended _____ DD / MM / YYYY

Do you intend to replace any existing health insurance coverage (other than coverage you may have had through an employer group benefits plan) with this insurance coverage?

☐ Yes ☐ No

If "Yes", please do not cancel your existing coverage. A replacement form or declaration may be required. Before completing the rest of this application form, please contact us at 1-888-640-8658. We may not be able to issue an insurance policy if replacement is indicated.

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):
I hereby designate the individual(s) named as beneficiary(ies) to receive any death benefit payable with respect to the coverage applied for:

Applicant's Beneficiary

Last Name _____

First Name _____

Relationship to Applicant _____

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid to the tutor or administrator.

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Co-Applicant's Beneficiary

Last Name _____

First Name _____

Relationship to Co-Applicant _____

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid to the tutor or administrator.

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Part B – Plan Choice

Remember: Your Plan Choice applies to all family members.

I/We apply for:

CORE PLANS

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

ADD-ONS Available only with a Core plan

- ☐ Travel*[1] +8 days
- ☐ Travel*[1] +21 days
- ☐ Accidental Death & Dismemberment Enhanced*
- ☐ Hospital Basic
- ☐ Hospital Enhanced
- ☐ Vision Enhanced* (Not available with ComboPlus Starter)

STAND-ALONES Available without a Core plan

- ☐ Hospital Basic
- ☐ Hospital Enhanced

*These plans do not require completion of the Medical Questionnaire of this application.
[1] Travel coverage ceases at age 70.

Part C – Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months premium, $_____from my/our:

Option #1 ☐ Financial Services Account (Pre-Authorized Debit)
Option #2 ☐ Credit Card Account

Subsequent Payments will be made by:

Option #1 ☐ Pre-Authorized Debit (PAD) from my/our Financial Services Account
PAD Billing Frequency: ☐ Monthly ☐ Semi-Annually (2% discount) ☐ Annually (4% discount)
Important: for verification purposes, we require a sample cheque marked 'VOID'. Please complete Part D.

Option #2 ☐ Credit Card Account
Credit Card Billing Frequency: ☐ Monthly ☐ Semi-Annually ☐ Annually
Please note: billing frequency discounts are not available for credit card payment options. Please complete Part D.

Option #3 ☐ Direct Billing
Direct Billing Frequency: ☐ Semi-Annually (2% discount) ☐ Annually (4% discount)

Part D – Payment Information and Authorization

PAYMENT INFORMATION

For Pre-Authorized Debit (PAD) payment options

Name of Account holder _____ Financial Institution _____

Address _____ City/Town _____

Bank Account Number _____ Transit Number _____

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ 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.

For Credit Card payment options

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Account Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date ☐☐☐☐

Name of Cardholder _____ Signature of Cardholder _____

PAYMENT AUTHORIZATION

For Pre-Authorized Debit (PAD) payment options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We or Manulife may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-COVER ME® (1-877-268-3763), www.coverme.com or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Name of Account holder _____ Signature of Account holder _____

Second signature if joint account _____ Dated DD / MM / YYYY

For Credit Card payment options

I/We hereby authorize Manulife 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 or by me/us through written notice.

Manulife 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 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

Second signature if joint account _____ Dated DD / MM / YYYY

Flexcare Medical Questionnaire for residents of Quebec – 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.

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

You may detach the Flexcare Medical Questionnaire and mail it to Manulife separately.
If you choose to do so, please complete the following:

Applicant's Last Name _____

First Name _____ Initial _____

Home Telephone _____

Section A – Individuals to be Covered

LAST NAME / FIRST NAME	VALID PROVINCIAL HEALTH CARD	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 FOR WEIGHT CHANGE
APPLICANT	☐ Yes ☐ No	00								
CO-APPLICANT	☐ Yes ☐ No	01								
DEPENDANT	☐ Yes ☐ No	02								
DEPENDANT	☐ Yes ☐ No	02								
DEPENDANT	☐ Yes ☐ No	02								
DEPENDANT	☐ Yes ☐ No	02								

Section B – Treating Qualified Health Care Practitioner

Must be completed in full for all plans <u>except</u> 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	For Applicant	For Co-Applicant	For Dependant(s)
Name of Primary Health Care Provider			
Address of Primary Health Care Provider			
Date of last Consultation			
Reason for last Consultation			
Diagnosis made			
Treatment given			

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

Date and Reason for Consultation _____

To which individual applying for coverage does this apply? _____

_____

Section C – Simplified Underwriting Questionnaire

Must be completed in full for all plans <u>except</u> DentalPlus and ComboPlus Starter.

Additional medical information may be required to underwrite your application.

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 medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? (Do not include any minor ailments such as the cold or flu.) ☐ Yes ☐ No

If you answered, "Yes" to any question above, please complete section D.

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.

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

Section D – Medical Declaration

Must be completed in full for all plans <u>except</u> DentalPlus and ComboPlus Starter.

Additional medical information may be required to underwrite your application.

<u>IMPORTANT</u>: Any reference to testing, tests, test results, or investigations in this section excludes genetic tests.

Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

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, High Cholesterol, any Circulatory or Blood Disorder ☐ Yes ☐ No

b) Heart or Blood Vessel Disorder, Heart Murmur, Chest Pain, Angina, Stroke or Transient Ischemic Attack (TIA) ☐ Yes ☐ No

c) Back, Neck, Disc, Hip, Knee or Joint Pain or Disorder, Fibromyalgia,Osteoporosis, Osteopenia, Chronic Pain, Paralysis, Weakness or Numbness or any other Musculoskeletal Pain or Disorder ☐ Yes ☐ No

d) Digestive System Disorder, Crohn's Disease, Ulcerative Colitis, Liver Disease or Disorder including Hepatitis or Hepatitis Carrier State ☐ Yes ☐ No

e) Mental, Nervous, Emotional or Neurological Disorder including Depression, Anxiety, Attention Deficit Disorder or Stress ☐ Yes ☐ No

f) Alcohol or Drug Abuse, or any Addiction ☐ Yes ☐ No

g) Allergies, Asthma, Bronchitis, Respiratory Disorder, Shortness of Breath or Sleep Apnea ☐ Yes ☐ No

h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) ☐ Yes ☐ No

i) Arthritis, Rheumatism or Rheumatoid Arthritis ☐ Yes ☐ No

j) Cancer, Tumor, Cyst, Polyp or any Growth ☐ Yes ☐ No

k) Skin Disorder ☐ Yes ☐ No

l) Breast Disorder, Menopause, Reproductive Disorder, Infertility or Assisted Conception ☐ Yes ☐ No

m) Bladder, Kidney or Prostate Disorder or other Genitourinary Disorder ☐ Yes ☐ No

n) Headaches or Migraines ☐ Yes ☐ No

o) Diabetes, Endocrine Disorder, Pituitary or Thyroid Disorder or Lupus ☐ Yes ☐ No

p) Eye or Ear Disorder ☐ Yes ☐ No

q) Any other Complaint, Condition, Disease or 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 **<u>not</u> stated above**?

Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant ☐ 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 ☐ Yes ☐ No

4. Have you, your co-applicant or any listed dependant been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years?

Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant ☐ Yes ☐ No

5. If answer is "Yes" to questions 1 to 4 of Section C, please give explanation below:

Question No.	Name of individual with condition	Illness/condition/diagnosis	Date Diagnosed	Duration	Name and address of Qualified Health Care Practitioner	Current status of condition

6. Are you, your co-applicant or any listed dependant currently using or expect to use in the next 3 months, or have you discontinued use in the last 3 months of any drug, medication, serum or other treatment?

If "Yes", provide details below:

Name of Individual	Name of drug medication serum/treatment	Condition being treated	Strength and daily dosage of the drug/ medication/serum	Length of time on this drug/ medication serum/treatment	Date discontinued
					DD/MM/YYYY
					DD/MM/YYYY
					DD/MM/YYYY
					DD/MM/YYYY

7. Are you, your co-applicant or any listed dependant pregnant? ☐ Yes ☐ No

If "Yes", Name of pregnant individual _____ Due Date (dd/mm/yyyy)_____DD/MM/YYYY_____

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

Flexcare Medical Questionnaire for residents of Quebec – Page 5

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.

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

Applicant's Declaration and Authorization - All applicants must complete this section

I/We the undersigned applicant(s) hereby apply for insurance to The Manufacturers Life Insurance Company. 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 or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife 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 or of the coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. Manulife 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. I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death. A photocopy of this signed authorization shall be as valid as the original.

Signature of Applicant _____ Dated (dd/mm/yyyy) _____DD/MM/YYYY_____

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

Plan underwritten by

The Manufacturers Life Insurance Company.

Manulife