coverme™

Application for CoverMe™ Easy Issue Life Insurance
The Manufacturers Life Insurance Company

AIR MILES® Collector #: 8

Primary Applicant Information

Last Name

First Name   Initial

Address

City

Province   Postal Code

Date of Birth (DD / MM / YYYY)   Age   ☐ Male ☐ Female

Telephone (Res.) (   )

Telephone (Bus.) (   )

E-mail

Are you also applying for health coverage with Manulife? ☐ Yes ☐ No

Choice of Coverage

I apply for CoverMe Easy Issue Life coverage: (Please select ☑ one)

☐ $50,000 ☐ $75,000

I confirm my smoking status as:

☐ Smoker

☐ Non-Smoker

Non-smoker status applies to people who have not used tobacco, tobacco cessation products or marijuana in the past 12 months. Smoking status is determined when your coverage is approved.

Your Health Declaration

1. Have you been diagnosed with a life threatening, critical or terminal condition for which your physician has estimated you have 24 months or less to live?

   ☐ Yes ☐ No

2. Within the last 3 years, have you had any indication of, or been treated for any of the following:
   - any heart disorder or blood vessel disorder, chest pains or heart murmur;
   - metastatic cancer;
   - a chronic infection or immune deficiency disorder, including HIV;
   - any disorder of the brain or disorder of the nervous system?

   ☐ Yes ☐ No

If you have answered "Yes" to either or both of the questions above, we regret that you are not eligible for CoverMe Easy Issue Life coverage.

Your Existing Coverage

Do you intend to replace any existing life 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.

Spouse Information (if applying for coverage)

Last Name

First Name   Initial

Address (if different than that of Primary Applicant)

City

Province   Postal Code

Date of Birth (DD / MM / YYYY)   Age   ☐ Male ☐ Female

Telephone (Res.) (   )

Telephone (Bus.) (   )

E-mail

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Beneficiary Information

Beneficiary on Primary Applicant's Coverage

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

Last Name ______ First Name ______

Relationship to Primary Applicant ______

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed.

By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the Trustee to hold in trust for the child until the child comes of age.

Name of Trustee ______

Relationship to Beneficiary ______

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

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.

Beneficiary Information

Beneficiary on Spouse's Coverage

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

Last Name ______ First Name ______

Relationship to Spouse ______

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed.

By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the Trustee to hold in trust for the child until the child comes of age.

Name of Trustee ______

Relationship to Beneficiary ______

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

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.

Payment Options

I/We hereby authorize Manulife to debit the initial premium, $ ______ , and subsequent premiums, from my/our:

Option #1

☐ Credit Card Account:
Credit Card Billing Frequency: ☐ Monthly - with AIR MILES® reward miles
☐ Annually - without AIR MILES reward miles

Option #2

☐ Pre-Authorized Debit (PAD) – monthly with AIR MILES® reward miles
Important: for verification purposes, we require a sample cheque marked "VOID".

Payment Information and Authorization

Payment Information

For Credit Card payment options

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Account Number ______ Expiry Date ______ MM / YYYY

Name of Cardholder ______ Signature of Cardholder ______

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.

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Payment Authorization

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

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

Declaration – Please read carefully before signing.

I/We, the undersigned applicant(s), hereby apply for insurance to The Manufacturers Life Insurance Company. I/We declare that the statements contained in this application 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 understand that any material misrepresentation, including misstatement of smoking status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date is a risk not covered. I/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that insurance will take effect on the date the application and payment of the first premium are received by Manulife at its office.

I/We hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my/our death.

I/We acknowledge receipt of, and agree with, the Notice on Privacy and Confidentiality and Notice on Information provided to the AIR MILES® Reward Program.

A photocopy of this signed authorization shall be as valid as the original.

Signed at ______________ (city, province) Dated ______________ DD / MM / YYYY Applicant's Signature ______________________

Signed at ______________ (city, province) Dated ______________ DD / MM / YYYY Spouse's Signature ______________________ (if applying for coverage)

Plan underwritten by **The Manufacturers Life Insurance Company.**

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