coverme™

Application for CoverMe™ Term Life Insurance
The Manufacturers Life Insurance Company

AIR MILES® Collector #: 8

1XX03 002 WSE XX

Part A — Applicant Information

Last Name _____ First Name _____ Initial _____

Address _____

City _____ Province _____ Postal Code _____

❑ Male ❑ Female Date of Birth _____ Age _____ Country of Birth _____

D D / M M / Y Y Y Y

Home Telephone _____ Office Telephone _____

E-mail _____

Occupation _____ Are you self-employed? ❑ Yes ❑ No

If "Yes", please describe the nature of your business/duties _____

_____

Part B — Your Choice of Coverage

I apply for CoverMe Term Life coverage:

Amount of coverage $ _____ (Available from $100,000 to $1,000,000 in increments of $25,000)

Applicant: ❑ Smoker ❑ Non-Smoker*

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

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

Part C — Beneficiary Information

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. (If no beneficiary is designated, benefits will be payable to your Estate.)

Beneficiary(ies):

1. Last Name _____ First Name _____

   Relationship to You, the Applicant _____ % of Benefit _____

2. Last Name _____ First Name _____

   Relationship to You, the Applicant _____ % of Benefit _____

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.

Trustee:

Last Name _____ First Name _____ Relationship to the Beneficiary(ies) _____

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.

Part D — Your Financial Information

Complete only if your total life insurance coverage (applied for and existing, from all companies) exceeds $250,000 of coverage.

Annual Net Earned Income (after expenses but before taxes) $_____

Part E — Information about Your Existing Coverage

Do you currently have health coverage with Manulife? ❑ Yes ❑ No

If "Yes", please provide your Policy # _____

Do you have any pending or existing life insurance coverage with Manulife or any other company? ❑ Yes ❑ No

If "Yes", please complete the following:

Company Name	Personal or Business	Amount of Coverage	Do you intend to replace with CoverMe Life coverage?*
		$	❑ Yes ❑ No
		$	❑ Yes ❑ No

*Note: If you intend to replace coverage (other than coverage you may have had through an employer group benefits plan), 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.

Part F — Your Payment Options, Information and Authorization

Pay monthly by credit card or PAD and collect AIR MILES® reward miles every month.

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

For Credit Card payment options

Credit Card: ❑ Visa ❑ MasterCard ❑ American Express

Account Number _____ Expiry Date _____
MM/YYYY

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.

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

Quebec residents may mail the following Health Declaration separately to the insurer.
This application is not valid unless a properly completed Health Declaration is received by Manulife.

Part G — Your Health Declaration

Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.

Your Physician's Name _____

Physician's Address _____ Telephone _____

Your height _____ ❑ ft. & in. / ❑ cms. Your current weight _____ ❑ lbs. / ❑ kgs.

Have you:	YES	NO
1. Ever applied for any insurance that was declined, modified or rated? If "Yes", please give date, name of company and reason: _____	❑	❑
2. Within the past 5 years, had your driver's license suspended or been convicted of impaired driving or had more than 3 driving violations? If "Yes", give details including: Nature of offence _____ Date(s) _____ Driver's License # _____ Licensing province _____	❑	❑
3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If "Yes", give details including type of activity and date(s): _____	❑	❑
4. Within the next 12 months, any intention of traveling or residing outside North America? If "Yes", please give details including where, when, why and for how long: _____	❑	❑
5. Within the past 7 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? If "Yes", please give details including drug or alcohol type(s) and date(s) last used: _____	❑	❑
6. Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), kidney disorder, urinary abnormality or prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned?	❑	❑
7. Ever had any positive test, treatment for/exposure to HIV virus or AIDS?	❑	❑
8. Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu, etc.), been advised to undergo further investigation, see another doctor or have surgery?	❑	❑

If you have answered "Yes" to questions 6,7, and/or 8 above, please give details below.
(If you require additional space, please attach a separate sheet, signed and dated.)

Question #	Nature of Disorder	Date and Duration	Result	Attending Physician or Hospital

Note: The insurer may request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant(s). Results of any positive infectious disease tests will be reported to the appropriate provincial health department if required by law.

For Quebec residents only:
If you are mailing your Health Declaration to Manulife separately, please complete the following:

Applicant's
Last Name _____ First Name _____ Initial _____ Home Telephone _____

Part H — Your Family History

	YES	NO
1. Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?	❑	❑
2. Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotropic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, retinitis pigmentosa or any hereditary disease?	❑	❑

If you have answered "Yes" to question 1 and/or 2 above, please give details below.

Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause, if applicable

Part I — Declaration Please read carefully before signing.

I hereby apply for insurance to The Manufacturers Life Insurance Company.

I declare that the statements contained in this application, including the Health Declaration originally attached hereto, are true and complete. I declare that I am resident in Canada and at least 18 but not yet 71 years of age. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any policy issued hereunder. I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I understand that suicide within the first two years is a risk not covered and that other exclusions and limitations apply to the coverage applied for. Relative to the insurance applied for, I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB Inc., any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health or the health of any member of my family to be insured under this plan to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose.

I acknowledge receipt of and confirm my agreement with, the Notice on Exchange of Information, Notice on Information provided to the AIR MILES® Reward Program, and the Notice on Privacy and Confidentiality.

I hereby designate the individual named as beneficiary to receive the proceeds payable upon my death.

I declare that I have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any policy issued as a result of this application. I understand that this consent may be revoked at any time and that if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

The party has expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

I understand that any health information must be accurate as at the date the application is signed and that I am not eligible for insurance under more than one CoverMe Term Life policy issued by Manulife. If I am approved, I will receive a policy specifying the coverage provided. If I am not insurable, a full refund of the premiums will be made.

A photocopy or faxed copy of this authorization shall be as valid as the original.

Signed At _____
(city, province)

Dated _____
DD/MM/YYYY

Signature of Applicant _____

Send your completed application form along with your initial premium payment to Manulife in the business reply envelope provided.
If you need assistance, call Manulife at
1-877-COVER ME®† (1-877-268-3763), Monday to Friday from 8 a.m. to 8 p.m. ET.

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

Manulife