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

Preferred Contact Phone Number _____ E-mail _____

Occupation _____

☐ Smoker ☐ Non-Smoker*

*Non-smoker status applies to people who have not used tobacco or tobacco cessation products in the past 12 months.

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)

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 the 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 become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Trustee:

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

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

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

What is your annual earned income (income after expenses and before taxes)? $_____

What is your personal net worth (assets minus liabilities)? $_____

Part E — Information about Your Existing Coverage

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

If "Yes", complete the following:

Company Name	Personal or Business	Amount of Coverage	Do you intend to replace this coverage?*
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

* Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Part F — Your Payment Method (Please select Option #1 or Option #2)

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

OPTION #1: CREDIT CARD AUTHORIZATION

☐ Credit Card:
☐ Visa ☐ MasterCard ☐ American Express ☐ Monthly ☐ Annually

Account Number _____-_____-_____-_____ Expiry Date _____/_____ (MM/YYYY)

OPTION #2: PAYMENT BY CHEQUE

☐ Monthly Pre-Authorized Debit – PAD (Please enclose a sample cheque marked "VOID")
☐ Annually (Please enclose a cheque payable to Manulife)

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 ☐ 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 financial institution is required for pre-authorized payments from accounts with no chequing privileges, I have made prior arrangements to allow for pre-authorized payments from my account. Enclosed is a withdrawal slip that has been stamped by my financial institution allowing withdrawals to be made from my non-chequing account.

Payment Authorization

For Credit Card payment options

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.

I hereby authorize Manulife to make a withdrawal from my 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 through written notice.

Name of Cardholder _____ Signature of Cardholder _____

Second Signature if Joint Account _____ Dated _____
DD/MM/YYYY

For Pre-Authorized Debit (PAD) payment options

I authorize Manulife to withdraw the premium amount of $_____from my bank account for monthly insurance premiums due on or after the date I sign this authorization. I authorize Manulife to withdraw premiums on or about the first business day of each month or the next business day thereafter. Withdrawals from my account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. **I waive the right to receive 10 days' notice of the amount and date of each automatic withdrawal from my account.** If my 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 me for an alternate method of payment if my payment is not honoured. All one-time or automatic withdrawals from my bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I and/or Manulife can end this agreement at any time by giving 10 days' written notice. I understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Manulife receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-COVER ME® (1-877-268-3763), am_service@manulife.com or write to us at Manulife, P.O. 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.payments.ca.

Name of Account holder _____ Signature of Account holder _____

Second signature if Joint Account _____ Dated _____
DD/MM/YYYY

Account Holder Address (if different from Applicant) _____

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 Personal Information

Have you:

	YES	NO
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:	☐	☐
2. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your license suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a license suspension or revocation, provide details including date the license was suspended or revoked:	☐	☐
b) Within the past 2 years, been charged with or convicted of 2 or more moving or traffic violations? (for example, speeding, failure to stop, seat belt violations, distracted driving, or failure to provide a breathalyzer sample) If yes, please provide full details; nature of offence(s), date(s), driver's license # and 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: a) Any expectation to travel outside of Canada and the United States of America? If yes, give details including where, when, why and for how long:	☐	☐
b) Any expectation to change your country of residence? If yes, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing:	☐	☐
5. Within the past 5 years: a) Used any drugs for other than medical purposes, used marijuana, or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug or alcohol type(s) and date(s) last used:	☐	☐
b) Been convicted of a criminal offense or are you currently charged with one? If yes, please provide details:	☐	☐
c) Declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge:	☐	☐

IMPORTANT: 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.

Your Medical Information

Physician's Name: _____

Physician's Address and Telephone Number: _____

Date, reason, and result of last consultation, and if any treatment or medication prescribed:

_____

Height: _____ ft & ____ ☐ in ☐ cm Weight: _____ ☐ lb ☐ kg

Has your weight changed in the past year? ☐ Yes ☐ No

If yes: ☐ Gained _____ ☐ lb ☐ kg ☐ Lost _____ ☐ lb ☐ kg

Reason for change: _____

Part G — Your Health Declaration (continued)

	YES	NO
1. **Have you ever had any indication of or been treated for conditions involving any of the following:**		
a) **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐	☐
b) **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐	☐
c) **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐	☐
d) **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐	☐
e) **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐	☐
f) **Your brain or nervous system** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐	☐
g) **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐	☐
h) **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐	☐
i) **Your blood or glands**, such as: Diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐	☐
j) **Your muscles, bones, or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?	☐	☐
k) **Your skin**, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐	☐
l) **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐	☐
m) Cancer, cysts, lumps, polyps, or tumour?	☐	☐
n) Other illness or disorder not mentioned above or, are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐	☐
2. **If female**, a) are you currently pregnant?	☐	☐
If yes, give due date and the name and address of your obstetrician/gynecologist: _____		
b) What was your pre-pregnancy weight? _____ lb _____ kg		
c) Have there been any complications with your pregnancy? If yes, provide details: _____	☐	☐
3. Within the past 2 years, have you:		
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐
b) Consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu, etc.)	☐	☐
c) Been advised to undergo further investigation, seen another doctor or have surgery?	☐	☐
Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐

If you answered yes to any of the questions above, please give details below:

Question #	Nature of Disorder	Date and Duration	Treatment (If None, State "None") & Current Status	Attending Physician or Hospital
1				
2				

Your Family Medical History

4. Have any of your parents or siblings (brothers or sisters):		
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐
b) Been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, or retinitis pigmentosa?	☐	☐

If you answered yes to a) or b) above, please complete the following:

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

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 — Notice on Exchange of Information

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Manulife or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (416) 597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. Information for consumers about MIB may be obtained on its website at www.mib.com.

Part I — Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, ON, N2J 4C6.

Part J — Declaration and Authorization Please read carefully before signing.

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

I declare that the statements contained in this application, including but not limited to the Health Declaration originally attached hereto, are true and complete and, together with any other forms signed by me in connection with this application, form 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, and that suicide within two years of the effective date is a risk not covered. I understand that other exclusions and limitations will apply to the coverage applied for. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, MIB, Inc., any insurance company, agent, broker, market intermediary, plan sponsor, group policy administrator 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 or my health, or the health of any member of my family to be insured under this plan, to provide such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I further authorize Manulife to consult this application and its existing files for this purpose. I understand that in connection with this application, Manulife may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant and that any positive infectious disease results will be reported to the appropriate health department if required by law. I understand the reason why the health information is needed and the risks and benefits of consenting or refusing to consent.

I understand that insurance will take effect on the date my properly completed application (including the Health Declaration) and the first premium are received by Manulife, subject to approval of the company's underwriters. If my application is approved, I will receive a policy specifying the coverage provided and the main policy provisions.

I hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds in accordance with any certificate/policy issued hereunder.

I acknowledge my receipt of and agreement with the Notice on Privacy and Confidentiality.

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

Signed At _____ Dated _____ Signature of Applicant _____
(city, province) DD/MM/YYYY

Send your completed application form along with your initial premium payment to
Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.
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.

Manulife

Plan underwritten by The Manufacturers Life Insurance Company.