

AIR MILES®  
Collector #: | 8 | | | | | | | | | | | | | | | | | | | | | |

**WSE**

Primary Applicant Information	Secondary Applicant Information
Last Name _____	Last Name _____
First Name _____ Initial _____	First Name _____ Initial _____
Address _____ _____	Address _____ _____
City _____	City _____
Province _____ Postal Code _____	Province _____ Postal Code _____
Date of Birth _____ Age ____ <input type="checkbox"/> Male <input type="checkbox"/> Female <small>DD / MM / YYYY</small>	Date of Birth _____ Age ____ <input type="checkbox"/> Male <input type="checkbox"/> Female <small>DD / MM / YYYY</small>
Telephone (Res.) ( _____ ) _____	Telephone (Res.) ( _____ ) _____
Telephone (Bus.) ( _____ ) _____	Telephone (Bus.) ( _____ ) _____

Please note: Each applicant will receive a separate policy.

**Choice of Coverage**

Primary Applicant	Secondary Applicant
<b>I apply for CoverMe<sup>TM</sup> Critical Illness coverage:</b> (Please select <input checked="" type="checkbox"/> one)	<b>I apply for CoverMe<sup>TM</sup> Critical Illness coverage:</b> (Please select <input checked="" type="checkbox"/> one)
<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$25,000 with Return of Premium Option	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$25,000 with Return of Premium Option
At a monthly premium of \$ _____ (Remember, you are eligible to apply for \$25,000 of coverage if you are a Canadian resident 18 - 65 years of age. However, to apply for \$25,000 of coverage with the Return of Premium Option, you must be 18 - 55 years of age.)	At a monthly premium of \$ _____ (Remember, you are eligible to apply for \$25,000 of coverage if you are a Canadian resident 18 - 65 years of age. However, to apply for \$25,000 of coverage with the Return of Premium Option, you must be 18 - 55 years of age.)
<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$50,000 with Return of Premium Option	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$50,000 with Return of Premium Option
At a monthly premium of \$ _____ (Remember, you are eligible to apply for \$50,000 of coverage if you are a Canadian resident 18 - 60 years of age. However, to apply for \$50,000 of coverage with the Return of Premium Option, you must be 18 - 55 years of age.)	At a monthly premium of \$ _____ (Remember, you are eligible to apply for \$50,000 of coverage if you are a Canadian resident 18 - 60 years of age. However, to apply for \$50,000 of coverage with the Return of Premium Option, you must be 18 - 55 years of age.)
<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$75,000 with Return of Premium Option	<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$75,000 with Return of Premium Option
At a monthly premium of \$ _____ (Remember, you are eligible to apply for \$75,000 of coverage or \$75,000 of coverage with the Return of Premium Option if you are a Canadian resident 18 - 55 years of age.)	At a monthly premium of \$ _____ (Remember, you are eligible to apply for \$75,000 of coverage or \$75,000 of coverage with the Return of Premium Option if you are a Canadian resident 18 - 55 years of age.)
<b>I confirm my smoking status as:</b> (Please select <input checked="" type="checkbox"/> one)	<b>I confirm my smoking status as:</b> (Please select <input checked="" type="checkbox"/> one)
<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker*	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker*

\*Non-smoker status applies to people who have not used any tobacco, nicotine substitutes, tobacco cessation products or marijuana within the last 12 months. Smoker status is determined when your coverage is approved.

For Quebec Residents Only	
<b>Primary Applicant</b>	<b>Secondary Applicant</b>
Do you intend to replace any existing insurance coverage (other than coverage you may have had through an employer group benefits plan) with this insurance coverage?	Do you intend to replace any existing insurance coverage (other than coverage you may have had through an employer group benefits plan) with this insurance coverage?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	

**Payment Options – Pay monthly by Credit Card or Pre-Authorized Debit (PAD) and collect AIR MILES® reward miles**

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.

**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](http://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](http://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](http://www.cdnpay.ca).

Name of Account holder \_\_\_\_\_ Signature of Account holder \_\_\_\_\_

Second signature if joint account \_\_\_\_\_ Dated \_\_\_\_\_  
DD / MM / YYYY

**Declarations** – Please read carefully before signing.

**Health Declaration**

I/We declare that during the past 10 years I/we have not been diagnosed with, had any signs and/or symptoms of, or had any medical consultations and/or abnormal tests for the following disorders:

- Cancer, Intracranial Tumour
- Heart Disease (including but not limited to Angina and Heart Attack), Stroke, Transient Ischemic Attack (TIA), Peripheral Vascular Disease or Diabetes
- Hepatitis, including Hepatitis Carrier State, Chronic Kidney Disease, AIDS or HIV
- Alcoholism or Drug Abuse

I/We declare that I/we have not had, during the last 10 years, Coronary Artery Bypass surgery and/or Aortic surgery.

I/We also declare that I/we have not undergone any tests for which I/we currently await results and I/we have not been advised to undergo any tests which have not yet been completed.

**General Declaration**

I/We the undersigned applicant(s) hereby apply for insurance to The Manufacturers Life Insurance Company.

I/We declare that I/we are Canadian resident(s) between the ages of 18 and 65 years. I/We understand that my/our coverage will come into effect on the first day of the month following the date my/our application is received and approved by Manulife.

I/We acknowledge and declare that I/we have read and understand the information concerning the terms of coverage under the plan and the limitations and exclusions applicable to such coverage, including those related to pre-existing conditions.

I/We declare that the information contained in this application is true and complete and forms the basis of any Policy issued hereunder.

I/We also declare that, if selecting a non-smoker benefit and premium option, I/we have not used any tobacco, nicotine substitutes, tobacco cessation products or marijuana within the last twelve (12) months. I/We agree that any material misrepresentation, including smoking status, will render the insurance voidable by Manulife.

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 \_\_\_\_\_ Dated \_\_\_\_\_ Primary Applicant's Signature \_\_\_\_\_  
DD / MM / YYYY

Signed at \_\_\_\_\_ Dated \_\_\_\_\_ Secondary Applicant's Signature \_\_\_\_\_  
DD / MM / YYYY  
(if applying for coverage)

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



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