Manulife

Application for Change to Non-smoker Rates
Affinity Markets – Policy Services

IMPORTANT NOTE:

1. To qualify for a change to non-smoker rates, the Insured must meet Manulife non-smoker definition and health standards.
2. Complete all answers in full for the insured person(s) applying for a change to non-smoker rates.

* **IMPORTANT:** Any reference to testing, tests, test results, or investigations **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 Plan member information

Applicant's name	Certificate/Policy number	Date of birth (dd/mmm/yyyy)
Spouse's name	Certificate/Policy number	Date of birth (dd/mmm/yyyy)
Address (number, street, apartment)		Telephone number ( )
City / Province		Postal code

2 Declaration

	Applicant information	Spouse information
1. Have you ever used tobacco, tobacco cessation products (e.g. Nicorette gum, Nicotine patch) or marijuana? **If *yes*, provide details below:**	◯ Yes ◯ No	◯ Yes ◯ No
Product type(s):		
Date(s) last used:		
2. Since the date of your last medical declaration to us: a) have you had or been treated for a mental or nervous disorder (depression, anxiety, etc.) disorder of the brain or nervous system, heart or circulatory disorder, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumor, lung or liver disorder, kidney disorder, urinary abnormality or prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder thyroid disorder, gastrointestinal disorder or other illness or injury other than minor ailments such as colds or flu etc?	◯ Yes ◯ No	◯ Yes ◯ No
b) have you consulted a physician other than for routine check-ups, received any medical advice or treatment, undergone any tests or taken medication?	◯ Yes ◯ No	◯ Yes ◯ No
3. Are you awaiting any pending tests, test results or investigations? **If you have answered *yes*, to questions 2 or 3 provide details below**	◯ Yes ◯ No	◯ Yes ◯ No

Name	Nature or disorder, test or investigation	Date	Duration (if applicable)	Result and current status	Name of attending physician or medical facility

4. a) Applicant's current: Weight ◯ lbs ◯ kg Height ◯ feet/inches ◯ centimetres	b) Spouse's current: Weight ◯ lbs ◯ kg Height ◯ feet/inches ◯ centimetres

3 Consent and authorization

The statements contained herein are true and complete, and together with other forms signed by me/us in connection with this application, form the basis for any certificate issued hereunder. I/We agree that any material misrepresentation, including misstatement of smoking status, shall render the policy change voidable at the instance of the insurer.

The statements contained herein are true and complete, and together with other forms signed by me/us in connection with this application, form the basis for any certificate issued hereunder. I/We agree that any material misrepresentation, including misstatement of smoking status, shall render the policy change voidable at the instance of the insurer. Relative to this application, I/we hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. or other organization, institution or person that has any records or knowledge of me/us or of any member of my/our family insured under this plan, or of our health, to give to the Manufacturers Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

All information requested will be for insurance purposes only and 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). MIB Inc. is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, MIB Inc. will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, MIB Inc. will arrange for disclosure to you of any information it may have in your file on you, your spouse or your children being insured under this plan. If you question the accuracy of the MIB Inc. file, you may contact the Bureau and seek a correction.

The address of MIB Inc. information office is: 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

Signed at	this	day of	,
Applicant signature			
Signed at	this	day of	,
Spouse signature (if applying for a spousal change)			

4 Instructions

Please send the completed form to:

Manulife
Attention: Affinity Policy Services
PO BOX 670
STN WATERLOO
WATERLOO ON N2J 4B8
Fax: 1-800-510-3362

5 Statement of confidentiality

The specific and detailed information requested on the Extended Health Care Claim form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (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, and administrators 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: Chief Privacy Officer, Manulife, PO BOX 1602, DEL STN 500-4-A, WATERLOO, ON N2J 4C6. A copy of our privacy policy is available on **manulife.ca**.

6 Accessibility statement

Manulife is committed to offering products and services to persons with disabilities, in ways that are consistent with the principles of dignity, independence, integration and equal opportunity. Manulife has a core belief that everyone should be treated with courtesy and respect and made to feel welcome. Manulife's accessibility policy allows you to receive this form in alternate formats upon request. Please contact us at accessibility@manulife.com, or call us at 1-855-891-8671, if you would prefer this document in an alternate format.
If you would like more details about accessibility at Manulife, we would encourage you to visit our website at **manulife.com/accessibility.**

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