Manulife

Group Benefits
Evidence of Insurability – Head Office Plans

Instructions - Please print all answers

1. Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box to indicate the type of coverage for which you are applying.

   ◯ **Plan member only** ◯ **Plan member and spouse** ◯ **Plan member, spouse and dependants** ◯ **Spouse and/or dependants**

2. Please ensure that **all sections** are completed.
   Section 1 - Plan sponsor's information - **to be completed first by plan administrator.**
   Sections 2, 3, 4, 5, 6 and 7 - Plan member/spouse/dependant information - To be completed by plan member/spouse and submitted to Manulife.

3. **If required, retain a photocopy for your files.**

1. Plan sponsor information

Plan contract number(s):

Division number:

Plan member certificate number:

Class:

Annual earnings:
$

Plan sponsor:

Eligibility date (dd/mmm/yyyy):

Plan administrator name:

Phone number:
( )

Email address:

Plan member's name (last, first and middle initial):

Date of birth (dd/mmm/yyyy):

*Select male, female or non-binary consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Language preference/Langue préférée:
◯ English/Anglais ◯ French/Français

Sex*:
◯ Male
◯ Female
◯ Non-binary

Province of residence:

Coverage being applied for:

◯ Late entrant

◯ Extended health care coverage ◯ Single ◯ Family ◯ Dependant

◯ Dental coverage ◯ Single ◯ Family ◯ Dependant

◯ Basic life

Plan member's present amount of coverage $

Additional amount requested $

Total amount requested $

◯ LTD/OPT LTD

Plan member's present amount of coverage $

Additional amount requested $

Total amount requested $

◯ STD

Plan member's present amount of coverage $

Additional amount requested $

Total amount requested $

◯ LTD Option: From: _____ To: _____ Life Option: From: _____ To: _____

Continued on the next page.

1. Plan sponsor information (continued)

◯ Optional life

Optional life amount :

Plan member's present amount of optional life	$		or		units of	$		or	x salary	$ 0.00 = $ 0.00
Additional amount requested	$		or		units of	$		or	x salary	$ 0.00 = $ 0.00
Total amount requested	$ 0.00	or	0	units of	$		or	0	x salary	$ 0.00 = $ 0.00

Spousal optional life amount:

Spouse's present amount of optional life	$		or		units of	$		or	x salary	$ = $ 0.00
Additional amount requested	$		or		units of	$		or	x salary	$ 0.00 = $ 0.00
Total amount requested	$ 0.00	or	0	units of	$		or	0	x salary	$ 0.00 = $ 0.00

◯ Dependant life Dependant life amount: $ _____

◯ Other: (Specify) _____

2. Plan member statement

*Select male, female or non-binary consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Plan member's name (last, first and middle initial): Occupation:

Sex*: ◯ Male ◯ Female ◯ Non-binary Date of birth (dd/mmm/yyyy): Home phone number: ( ) Business phone number: ( )

Plan member's address (number, street, apartment):

City: Province: Postal code:

Height: m cm ft in Weight: ◯ kg ◯ lb

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If **yes**, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason:

Name of personal physician (last, first and middle initial):

Address of personal physician (number, street, suite): Physician's phone number: ( )

City: Province: Postal code:

3. Spousal statement

*Select male, female or non-binary consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Spouse's name (last, first and middle initial):

Sex*: ◯ Male ◯ Female ◯ Non-binary Date of birth (dd/mmm/yyyy): Home phone number: ( ) Business phone number: ( )

Height: m cm ft in Weight: ◯ kg ◯ lb

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If **yes**, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb | Was this a gain or a loss? | Reason:

Continued on the next page.

3. Spousal statement (continued)

Name of personal physician (last, first and middle initial):

Address of personal physician (number, street, suite): Physician's phone number: ( )

City: Province: Postal code:

4. Dependant information

Please provide the following information for each dependant to be insured.
If you have more than three children, please attach separate sheet (signed and dated) and include all personal information as requested above.

Child's name (last, first and middle initial):

*Select male, female or non-binary consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Sex*: ◯ Male ◯ Female ◯ Non-binary

Date of birth (dd/mmm/yyyy):

Height: ___ m ___ cm / ___ ft ___ in

Weight: ☐ ◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If **yes**, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason:

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If **no,** please provide:

Name of personal physician (last, first and middle initial):

Address of personal physician (number, street, suite): Physician's phone number: ( )

City: Province: Postal code:

Child's name (last, first and middle initial):

*Select male, female or non-binary consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Sex*: ◯ Male ◯ Female ◯ Non-binary

Date of birth (dd/mmm/yyyy):

Height: ___ m ___ cm / ___ ft ___ in

Weight: ☐ ◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If **yes**, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason:

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If **no,** please provide:

Name of personal physician (last, first and middle initial):

Address of personal physician (number, street, suite): Physician's phone number: ( )

City: Province: Postal code:

Child's name (last, first and middle initial):

*Select male, female or non-binary consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Sex*: ◯ Male ◯ Female ◯ Non-binary

Date of birth (dd/mmm/yyyy):

Height: ___ m ___ cm / ___ ft ___ in

Weight: ☐ ◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If **yes**, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason:

Dependant physician - Is name of personal physician the same as member? ◯ Yes ◯ No If **no,** please provide:

Name of personal physician (last, first and middle initial):

Address of personal physician (number, street, suite): Physician's phone number: ( )

City: Province: Postal code:

5. Medical questions for proposed insured

Complete all questions below on behalf of **all** applicants. Provide full details to **all yes questions.**
If you require more room for **yes** answers please attach a separate sheet (signed and dated).

	Plan member	Spouse	Children
1. During the past 12 months have you a. flown as a pilot, student pilot or crew member or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
b. engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you a. ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
b. ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
c. been absent from work for medical reasons during the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
d. currently received any treatment/medications?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
e. any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you ever consulted a physician, ever been treated for, or had any known identification of a. chest pain, blood vessel disease, heart disorder, or heart attack or stroke?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
b. high blood pressure?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
c. allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
d. glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
e. epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinson's)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
f. nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
g. excessive use of alcohol or drugs?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
h. lung disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
i. bowel, stomach or liver disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
j. cancer?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
k. disorder of the kidney, urine or genital organs?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
l. arthritis, rheumatism or fibromyalgia?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
m. disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
n. immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
o. anemia, or other blood disorders?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Continued on the next page.

5. Medical questions for proposed insured (continued)

Please provide details below, if you have answered Yes to Any questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

Question number	Name of person (first & middle initial)	Details or name of condition	Date and duration	Medication/treatment and results (recovery or remaining effects)	Names and addresses of physicians and hospitals

	Plan member	Spouse	Children
5. Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease,diabetes (2 or more family members prior to age 50), chronic kidney disease, angina, stroke, multiple sclerosis,Huntington's disease, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60? If answered **yes**, please provide details in the chart below.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Plan member or spouse's family member	Relationship	Condition	Age at onset	Age at death (if applicable)
◯ Plan member ◯ Spouse ◯ Child				
◯ Plan member ◯ Spouse ◯ Child				
◯ Plan member ◯ Spouse ◯ Child				
◯ Plan member ◯ Spouse ◯ Child				

6. Authorization and consent

"We" refers to The Manufacturers Life Insurance Company (Manulife) and their affiliated companies and subsidiaries.

"You" refers to the person submitting this application.

Before you review your choices, read the information below.

Below you'll see the terms of this application for you and your spouse and/or your children. These terms are important. They describe what you're agreeing to when you apply for coverage, and how we deal with your information. So before you review your submission, read these terms carefully.

All information given, as well as any future verbal or written information relating to this application, is true and complete to the best of your knowledge.

If you give false, incomplete, or misleading information as part of this application, or in the future in connection with this application, you understand that, according to the terms of your group benefits plan:
- coverage for you and your spouse and your children may be void;
- claims under this coverage may be denied and not paid; and/or
- we may recover any money that was incorrectly paid to you

You understand that no coverage takes effect until we approve it.

Privacy
Protecting your personal information is important to you. It's important to us, too.

I authorize:
- Manulife and/or its service providers, its reinsurers, and their service providers to collect, use, maintain and disclose my personal information relevant to this application ("Personal Information") for the purposes of Group Benefits administration, audit and the assessment, investigation and management of this application, medical underwriting and/or other purposes identified in the Personal Information Statement for employers' Group Benefits plans (collectively, the "Purposes").
- Any person or organization who has Personal Information about me, including any medical and health care professionals, institutions, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each and with Manulife, its reinsurers and/or its service providers, for the Purposes.
- The use of my Social Insurance Number ("SIN") for the purposes of identification and administration if my SIN is used as my plan member certificate number.

I understand:
- That Manulife may investigate this application and may require Personal Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes.
- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- A decision about my application may be taken exclusively on the basis of an automated decision using my Personal Information.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. I may not withdraw my consent for Manulife to collect, use, or disclose Personal Information needed for my application. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my application.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.

Requests can be sent to: **Privacy Officer Manulife, P.O. Box 1602, Del Station 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**.

For more information, I can review the **Personal Information Statement for employers' Group Benefits plans.**

Applying to cover minor children and/or spouse
If you're applying for or submitting information about minor children and/or spouse, there are a few things you need to know.

By signing, you give us permission to and/or confirm that you have obtained the individual's consent for the collection, use, disclosure or otherwise processing of the individual's Personal Information for the Purposes (as these terms are defined above).

Your email
By giving us your email address, you're giving us permission to email you. If your email address changes, it's up to you to let us know.

Electronic consent
You understand and agree that for your application, we may
- communicate with you and provide you with required disclosures electronically
- use electronic records
- use electronic signatures

Continued on the next page.

6. Authorization and consent (continued)

You may revoke your electronic consent in writing at any time.

You've read the **Terms & Conditions** for Manulife's plan member website. You agree to follow these terms.

Your right to revoke
You can revoke your authorizations at any time by sending instructions in writing to us. You understand that if you do this, it may impact your application, the administration of future claims, and benefits payments.

Plan member's name (please print):

Plan member signature: Date signed (dd/mmm/yyyy):

Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form): Date signed (dd/mmm/yyyy):

7. Mailing instructions

Print

Please send the completed form to:

Group Medical Underwriting
Manulife
P.O. Box 1900, Station C
Kitchener, Ontario N2G 4R4

Phone: 1-800-268-6195 or 519-747-7000

Plan Member Website: Use the link under Contact Us in the main menu to send us your documents securely using the Send Documents feature.