Manulife

Application for reinstatement of life insurance
for policies that have lapsed within the past 6 months

Mail or fax completed form to
Manulife, Individual Insurance at:

In all provinces except Quebec
500 King Street North
P.O. BOX 1669
WATERLOO ON N2J 4Z6
Fax: 1-877-763-8834

In Quebec
2000 RUE MANSFIELD
BUREAU 1310
MONTREAL QC H3A 3A1
Fax: 1-877-271-5494

- *You* and *your* mean the policy owner unless otherwise identified. *We, us* and *our* mean the insurer of the policy identified in section 1.
- Use this form to reinstate a life insurance policy that lapsed within the past 6 months. Use *Application for change*, NN7001E (or *Manulife Quick Issue Term® Application for change*, NN7011E, if applicable), to reinstate a policy that lapsed more than 6 months ago.
- We may require further evidence of insurability to reinstate your policy.
- Should you have any questions about completing this form, contact your advisor or call our Customer Service Centre at 1-888-626-8843 in Quebec, or 1-888-626-8543 in all provinces except Quebec. If you are calling from outside of North America, call us collect at 1-519-747-6600. Visit **manulife.ca** for more information.

1 Information about the policy

Name of policy owner (first, middle initial, last)			Policy number
Name of advisor (first, middle initial, last)		Advisor code	Branch code
Name of insured person "A" (first, middle initial, last)		Date of birth (dd/mmm/yyyy – for example, 23/JUL/1948)	
Address	City	Province	Postal code
Name of insured person "B" (first, middle initial, last)		Date of birth (dd/mmm/yyyy – for example, 23/JUL/1948)	
Address	City	Province	Postal code

2 Evidence of insurability

In this section, *you* means any person insured under this policy including any person insured under a child protection rider or other rider.	**Person "A" to be insured**	**Person "B" to be insured**	**Children under a child rider**
1. Within the past year, have you been admitted or been advised to be admitted to a hospital or medical facility, or had surgery performed or recommended?	◯ No ◯ Yes	◯ No ◯ Yes	◯ No ◯ Yes
2. Within the past year, have you been treated for heart disease, diabetes, stroke or cancer, or has treatment for these conditions been recommended by a health care professional?	◯ No ◯ Yes	◯ No ◯ Yes	◯ No ◯ Yes
3. Within the past year, have you been absent from work for more than 10 consecutive days for any accident or sickness?	◯ No ◯ Yes	◯ No ◯ Yes	◯ No ◯ Yes
4. Have you ever been diagnosed with any immune deficiency disorder, including AIDS, AIDS Related Complex (ARC) or any generalized enlargement of the lymph glands or have you had any test results that indicate possible exposure to the AIDS (i.e. HIV, HTLV-III, LAV) virus?	◯ No ◯ Yes	◯ No ◯ Yes	◯ No ◯ Yes
5. Have you ever been declined for life, disability, critical illness or long-term care insurance, or been offered restricted coverage or coverage at a non-standard rate?	◯ No ◯ Yes	◯ No ◯ Yes	◯ No ◯ Yes

Details

If you answered *Yes* to any of the questions in section 2, list the question number and provide full details here, including dates (and the name and address of any doctor you consulted, if applicable). If you need additional space, you can attach a separate sheet of paper that has been signed, dated and witnessed.

3 Authorizations, agreements and signatures

At Manulife protecting your personal information and respecting your privacy is important to us.

"We", "us" and *"our"* refer to The Manufacturers Life Insurance Company (Manulife) and our affiliated companies and subsidiaries.

Please read this entire section carefully. It explains how your personal information is used to issue and administer the insurance policy you have applied for.

Why do we collect, use, and disclose your personal information?

For the purposes of establishing and managing our relationship with you, providing you with products and services, administering our business, and complying with legal and regulatory requirements.

What personal information do we collect?

Depending on the product or service, we collect specific personal information about you such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, driver's license, passport number or your Social Insurance Number (SIN)
- Financial information, investigative reports, credit bureau report, and/or a consumer report
- Information about how you use our products and services, and information about your preferences, demographics, and interests
- Banking and employment information
- Medical information that any organization or person has about you
- Any test that may be necessary for underwriting purposes
- Other personal information that we may require to administer your products or services and manage our relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

Depending on the product or service, we collect personal information from:

- Your completed applications and forms
- Other interactions between you and us
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal with in issuing and administering your products or services now, and in the future
  - Public sources, such as government agencies, credit bureaus and internet sites
  - Financial institutions
  - The MIB, LLC (formerly known as the Medical Information Bureau)
  - Health Care Professionals, including Medical Practitioners, health care institutions, pharmacy and any other medically-related facility

What do we use your personal information for?

Depending on the product or service, we will use your personal information to:

- Administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us make decisions and understand our customers better so we can improve the products and services we provide
- Perform audits, and investigations and protect you from fraud
- Determine your eligibility for, and provide you with details of, other products and services that may be of interest to you
- Automate processing to help us make decisions about your interactions with us, such as, applications, approvals or declines

3 Authorizations, agreements and signatures (continued)

Who do we disclose your information to?

Depending on the product or service, we disclose your personal information to:

- Persons, financial institutions, reinsurers, and other parties with whom we deal with in issuing and administering your product or service now, and in the future
- Authorized employees, agents and representatives
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your doctor
- Public health authorities as required

Except where there are contractual restrictions, these people, organizations and service providers are both within Canada and outside of Canada. Therefore, your personal information may be subject to interprovincial or cross-border transfers in order to provide services to you and subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

Withdrawing your consent

You may withdraw your consent for us to use your personal information for certain uses, subject to legal and contractual restrictions.

You may not withdraw your consent for us to collect, use, or disclose personal information we need to issue or administer your products and services. If you do so, we may not be able to provide you with the products or services requested or we may treat your withdrawal of consent as a request to terminate or refusal the product or service.

If you wish to withdraw your consent, phone our Customer Care Center at **1-888-MANULIFE (626-8543)** or **1-888-MANUVIE (626-8843)** in Quebec or write to the Privacy Officer at the address below.

Accuracy

It is your responsibility to notify us of any change to your contact information. Please contact us if your information has changed, or if you need to make a correction of any inaccuracies.

Access

You have the right to access and verify your personal information maintained in our 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 Stn 500-4-A, Waterloo, Ontario N2J 4C6** or Canada_Privacy@manulife.ca

For more information you can review our **Canadian Privacy Policy**. Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email.

Manulife, “we”, “us”, “our” refers to The Manufacturers Life Insurance Company— Canadian Division operations, Manulife Securities Inc., Manulife Securities Investment Services Inc., Manulife Securities Insurance Inc., Manulife Asset Management Limited, Manulife Assurance Company of Canada, First North American Insurance Company, Manulife Bank of Canada, and affiliates of these entities.

3 Authorizations, agreements and signatures (continued)

If You Have a Concern or Complaint

You may discuss any questions or concerns you may have by contacting your advisor or our head office. More information about our complaint resolution procedures is available on the internet at **manulife.ca** under *Contact Us*.

Terms for reinstating policies

If we agree to reinstate your policy, this form becomes part of that document.

This reinstatement form includes the pages numbered 1 to 5, any answers you have provided, plus all written statements submitted in connection with it.

By signing on the next page, you agree that:

- You ask us to reinstate the policy identified on page 1 of this form.
- A policy reinstatement will become effective when any payment due to us as a result of the reinstatement has been paid and the application for reinstatement has been approved by us at our head office provided there has been no change in the insurability of the insured person since this form was completed.
- We have the right to question the validity of the reinstatement if an insured person or a policy owner misrepresented a material fact (whether fraudulently or not) by not disclosing it or stating it incorrectly in any application or in any medical examination or in any information we have used as evidence of insurability.
- The contestability period for any insurance coverage is the first 2 years from these dates:
  - The effective date you made a change that required updated evidence of insurability for that coverage
  - The date your policy was last reinstated
  - The coverage issue date.
- If the age or sex of any insured person has been misstated, any benefit payable on any insurance or rider coverage for that insured person will be increased or decreased to the amount we would have paid based on the last premium paid for that coverage, and the amount of insurance the last premium would have purchased according to the insured person('s) correct age or sex. If we would not have issued the coverage, we have the right to declare the coverage invalid within the period permitted by law.
- We can contest with respect to fraud at any time.
- You understand that the authorizations you provide will remain in effect after the policy owner and the people to be insured die so that we can evaluate and review any claim under the policy and fulfill our legal requirements.
- If the premiums or payments for this policy are paid by automatic monthly withdrawal, and the policy lapsed within the past 3 months, we will resume the automatic monthly withdrawal plan and the holder(s) of the bank account from which withdrawals will be made:
  - Agree that we can increase the monthly withdrawal by the new amount required to keep the policy in effect as a result of this reinstatement
  - **Waive the right to receive 10 days' notice of the amount of automatic monthly withdrawal.**

If the premiums for this policy are paid by automatic monthly withdrawal, and the policy lapsed more than 3 months ago, the payor must complete the attached Request to change or create a new automatic monthly withdrawal plan, NN0312E to confirm the automatic withdrawal plan details for the reinstated policy.

3 Authorizations, agreements and signatures (continued)

Your advisor's access to your personal information

- If our findings concerning your blood pressure, cholesterol level or physical build affect your policy change or reinstatement, we may share this information with your advisor.
- If the information you provide in the application or in any telephone interview or paramedical interview affects your policy change or reinstatement, we may tell your advisor whether the relevant information relates to your family history, medical information or lifestyle.

You agree that we may share the information with your advisor as described above and that your advisor can use this information to discuss your insurance options with you. If you do not agree, select the applicable box.

Insured person "A" does not agree ◯

Insured person "B" does not agree ◯

Signatures

Please review this form, including the authorizations and agreements, and sign.

By signing here, you are confirming that:

- You understand that approval of the reinstatement is subject to contract provisions and our current administrative rules.
- You have read this form and confirm that the statements in it are complete, current and accurate. You will immediately notify us of any errors or omissions.
- You agree to the terms described in this form.
- A copy of this document is as valid as the original.
- **Quebec Residents Only:** You acknowledge that you were provided with the French application and any forms required to apply for insurance. You have expressly chosen to apply for insurance and to receive any forms required for the application of insurance in English.

Signed at (city or town, province)	Date (dd/mmm/yyyy – for example, 01/APR/2025)	
Signature of insured person "A" ✘	Signature of witness ✘	Date (dd/mmm/yyyy)
Signature of insured person "B" ✘	Signature of witness ✘	Date (dd/mmm/yyyy)
Signature of policy owner (if not insured person "A" or "B")* ✘ Title (if applicable)	Signature of witness ✘	Date (dd/mmm/yyyy)
Signature of policy owner (if not insured person "A" or "B")* ✘ Title (if applicable):	Signature of witness ✘	Date (dd/mmm/yyyy)

Initial here	Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.

*** If the owner is a corporation we require:**

- 2 signing officers' signatures and titles

  or

- 1 signing officer's signature, title and the corporate seal; if the corporation does not have a seal and you are the only person authorized to sign on behalf of the corporation, in addition to signing, write your initials in the box provided.

Authorizations for automatic monthly withdrawals (for account holders that are not insured people or policy owners) if the policy lapsed within the past 3 months

Name of account holder #1 (first, middle initial, last) (if that person has not signed above)	Name of account holder #2 (first, middle initial, last) (if that person has not signed above)
Signature of account holder #1* ✘ Title (if applicable):	Signature of account holder #2* ✘ Title (if applicable):
For corporations: Full legal name (including Company, Limited, Inc., etc.)	

Initial here	Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.

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intentionally.

Authorization to share information – Person A

You and *your* refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. *Us* and *our* refer to The Manufacturers Life Insurance Company (Manulife). By signing here, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, or of your children or their health (if applicable), to share or exchange information with us or applicable reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal health information to the MIB, LLC.

Signed at (city or town)	Date (dd/mmm/yyyy)
Signature of person "A" to be insured ✘	
Signature of witness ✘	

If the person to be insured is under age 18:
Relationship to the person to be insured:
◯ Mother ◯ Father ◯ Guardian (tutor, in Quebec)

Signature of parent or guardian/tutor ✘
Signature of witness ✘

Authorization to share information – Person B

You and *your* refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. *Us* and *our* refer to The Manufacturers Life Insurance Company (Manulife). By signing here, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, or of your children or their health (if applicable), to share or exchange information with us or applicable reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal health information to the MIB, LLC.

Signed at (city or town)	Date (dd/mmm/yyyy)
Signature of person "B" to be insured ✘	
Signature of witness ✘	

If the person to be insured is under age 18:
Relationship to the person to be insured:
◯ Mother ◯ Father ◯ Guardian (tutor, in Quebec)

Signature of parent or guardian/tutor ✘
Signature of witness ✘

Manulife

Receipt for payment

Amount received $

The premium must be paid by cheque in Canadian funds drawn on a Canadian financial institution, and made payable to Manulife Financial.

By signing here, the advisor confirms that this premium is for any life insurance applied for in this form, covering the people listed below.

Name of person "A" to be insured (first, middle initial, last)		Name of person "B" to be insured (first, middle initial, last)
Total amount of insurance coverage applied for $	Date (dd/mmm/yyyy)	Signature of advisor ✘

Detach and leave with policy owner

Manulife

MIB, LLC

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, LLC based on your application, or to other insurance companies to which you apply for life, health, or critical illness insurance, or to which a claim for benefits has been submitted.

MIB, LLC. operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply for to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB LLC, will, upon request, supply such company with the information in its file.

Personal information disclosed to MIB, LLC may include your name, birth jurisdiction, date of birth, occupation and medical information used to identify you and to determine your insurability.

If a brief report is made to MIB by Manulife, then it will be stored and safeguarded for such a period as may be allowed by law. MIB receives personal information about Canadian consumers and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. MIB has agreed to protect such information in a manner that is substantially similar to the privacy and security practices, of MIB's Canadian member companies, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. Information for consumers about MIB, LLC may be obtained on its website at **www.mib.com**.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 or go to its website at **www.mib.com** to request disclosure online. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

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Your right to access your personal information

You can ask to review your personal information in our files and have any inaccuracies corrected by sending a written request to:
Privacy office - Individual Insurance,
500 King St. N., P.O. Box 1669, Waterloo ON N2J 4C6

Where you can find more information about our privacy policy

To obtain a copy of our policies and practices for handling personal information, contact our privacy office at the address above, or visit **manulife.ca** and search for "privacy".

If You Have a Concern or Complaint

You may discuss any questions or concerns you may have by contacting your advisor or our head office. More information about our complaint resolution procedures is available on the internet at **manulife.ca** under *Contact Us*.

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