Manulife Financial

Group Benefits
Application for Insurance and Statement of Health for Self-Administered Plans

Instructions:

1. Please select who the application is for by clicking on the buttons below. Making this selection determines which parts of the form need to be completed.
2. Please complete all the required fields and sections highlighted in blue.
3. Note that some fields will **not** be highlighted which means that they do not apply to the benefits asked for and you do not need to complete those questions.
4. If you do not have information for a highlighted field type N/A.
5. Additional space to provide details to the medical questions is available at the end of Section 5 if you need more room for comments.
6. If required, retain a photocopy for your files.

Select who is applying for insurance.

◯ *EMPLOYEE* ◯ *EMPLOYEE AND SPOUSE* ◯ *EMPLOYEE AND CHILDREN* ◯ *EMPLOYEE, SPOUSE, AND CHILDREN* ◯ *SPOUSE AND/OR CHILDREN*

1. Plan sponsor information

Plan contract number(s)	Division number	Plan member certificate number	Class	Eligibility date (dd/mmm/yyyy)

Plan sponsor	Date completed (dd/mmm/yyyy)

Plan administrator name	Phone number Local number	E-mail address

Plan member's name (last, first and middle initial)	Date of birth (dd/mmm/yyyy)

Language preference/Langue préférée	Sex Male Female	Province of residence

Request is for: Increase to current coverage Late applicant

Coverage applying for: Complete the table below for benefit types that you are requesting new or increased coverage for.

			I CURRENTLY HAVE	I'M REQUESTING	TOTAL
Employee	Annual Salary $				
	Basic Life				
	Long Term Disability				
	Short Term Disability				
	Extended Health Care				
	Dental				
	Optional Life				
	Optional LTD				
	Other (specify)				
Spouse	Dependant Life				
	Extended Health Care				
	Dental				
	Optional Life				
Child/Children	Dependant Life				
	Extended Health Care				
	Dental				
	Optional Life				

2. Plan member (Employee) statement

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

Sex: Male Female | Date of birth (dd/mmm/yyyy) | Home phone number | Business phone number Local

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

City | Province | Postal code

By providing my personal e-mail address, I am authorizing Manulife to use the address provided as an additional means of communication about my life. I acknowledge that correspondence by e-mail may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.

E-mail address

Height | Weight | Has your weight changed in the past year? Yes No
If yes: Gained Lost How much weight is gained or lost?

Reason for change of weight | Have you smoked (cigarettes, cigars, pipe, etc.) or used products that contain nicotine or tobacco in any other form within the last 12 months? Yes No

Name of doctor (last, first and middle initial)

Address of doctor (number, street, suite) | Doctor's phone number

City | Province | Postal code

3. Spouse statement

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

Sex: Male Female | Date of birth (dd/mmm/yyyy) | Home phone number | Business phone number

Height | Weight | Has your weight changed in the past year? Yes No
If yes: Gained Lost How much weight is gained or lost?

Reason for change of weight | Have you smoked (cigarettes, cigars, pipe, etc.) or used products that contain nicotine or tobacco in any other form within the last 12 months? Yes No

Is name of your doctor the same as member? Yes No If "No," please provide:

Name of doctor (last, first and middle initial)

Address of doctor (number, street, suite) | Doctor's phone number

City | Province | Postal code

4. Dependant child statement

Please provide the following information for each child to be insured

Child's first and last name	Sex	Relationship to plan member	Date of birth (dd/mmm/yyyy)	Height (ft & in/cm)	Weight (lbs/kg)
	Male Female				
	Male Female				
	Male Female				
	Male Female				

Is name of child's doctor the same as member? Yes No If "No", please provide:

Name of doctor (last, first and middle initial)

Address of doctor (number, street, suite) | Doctor's phone number

City | Province | Postal code

5. Medical questions

Complete all questions below on behalf of all applicants. Provide full details to all Yes Questions.

1. Application	Employee	Spouse	Children
1a. In the past 5 years have you applied for life insurance that was declined, postponed or modified in any way?	Yes No	Yes No	Yes No
1b. In the past 5 years have you been absent from work for medical reasons?	Yes No	Yes No	Yes No
1c. Have you ever applied for or received benefits, compensation or pension because of sickness or injury?	Yes No	Yes No	Yes No

2. Medical

2a. Have you had or been treated for chest pain, heart murmur, high blood pressure, shortness of breath, heart disease or asthma?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2b. Have you had or been told you had a heart attack, angina, stroke, transient ischemic attack (TIA)?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2c. Have you had cardiac bypass surgery, stent placement or angioplasty?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2d. In the past 3 years have you consulted a doctor or been treated for diabetes, ulcer, colitis, urinary tract infection, tumour, cancer or any disease or disorder of the heart, blood, lungs, liver, kidneys or urine?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2e. Have you consulted a doctor or been treated for anemia or other blood disorders?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2f. Have you consulted a doctor or been treated for disorders of the stomach, bowel, reproductive organs or glandular disorders including thyroid disorders?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2g. Have you consulted a doctor or been treated for epilepsy or neurological disorders (For example: Multiple Sclerosis, Parkinson's)?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2h. Have you consulted a doctor or been treated for disorders of the muscles or bones including the back, spine or joints?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2i. Have you consulted a doctor or been treated for arthritis, rheumatism or fibromyalgia, chronic symptoms, chronic pain or Chronic Fatigue Syndrome?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2j. Have you consulted a doctor or been treated for allergies or skin disorders including growths or cysts?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2k. Have you consulted a doctor or been treated for an immune deficiency disorder or any generalized enlargement of the lymph glands?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2l. In the past 3 years have you consulted a doctor or been treated for sexually transmitted disease, mental illness, anxiety, depression, or an emotional condition?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2m. Have you had, have you ever been told you had, been tested for, or do you have the HIV or AIDS virus?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2n. In the past 3 years have you had surgery or been hospitalized?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2o. In the past 60 days, have you consulted a doctor or other health practitioner, had medical testing done for anything other than pregnancy or minor ailments (For example: sprains, cold or flu.) or are you receiving any treatment or taking medication?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2p. In the next 90 days, do you have medical tests scheduled or recommended for anything other than pregnancy, routine immunizations, flu shots or minor ailments (For example: cold or flu)?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

2q. Do you have a symptom or complaint or any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?

	Name of person:	Name of condition or details:	Date and duration:	Medication/treatment and results (recovery or remaining effects):	Name/address of doctor and hospitals:
Employee Yes No					
Spouse Yes No					
Children Yes No					

3. Health	**Employee**	**Spouse**	**Children**
3a. Have two or more immediate family members (For example: your parents or siblings) been diagnosed before age 50 with heart disease, stroke or cancer?	Yes No	Yes No	Yes No
3b. Do you have any family history or inherited or familial disease (For example: Huntington's Chorea, diabetes, heart or kidney disease?	Yes No	Yes No	Yes No
4. Lifestyle			
4a. In the past 12 months have you flown or intend to fly as a pilot, student pilot, or crew member?	Yes No	Yes No	Yes No
4b. In the past 12 months have you been or intend to parachute, hang glide, motor sport race, rock or glacier climb, under water dive or any other hazardous sport?	Yes No	Yes No	Yes No
4c. In the past 12 months have you used or smoked marijuana or hashish?	Yes No	Yes No	Yes No
4d. In the past 12 months have you smoked cigars? If yes, how many cigars have you smoked?	Yes No	Yes No	Yes No
4e. Have you ever been treated for, counselled, or advised to seek treatment for alcohol or drug abuse?	Yes No	Yes No	Yes No

Additional space for details

6 Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I authorize** 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 agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan member's name (please print)	
Plan member's signature	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if requesting benefits for spouse on this form)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

7 Submitting instructions

Once all required fields are complete, please print the form, sign it and date it. Use the PRINT button below to print the form.
If your spouse is an applicant, then both the member and the spouse must sign and date the form.

Send a scanned copy to us by
Email: EOI_Intake_Shared_Services@manulife.com
Or FAX: 519-883-5702

PRINT