HEALTH PLAN APPLICATION

flexCARE®
Manulife Financial

PAGE 1
***All applicants must complete parts A, B, C, D,.**
***All applicants must sign and complete**
Applicant's Declaration

For Manulife Financial Use Only.

Keyed _____

Approved _____

AIR MILES#: | 8 |__|__|__|__|__|__|__|__|__|__|__|

Sub-Broker ID (Office Use Only): _____

PART A - GENERAL INFORMATION

Applicant's Last Name:	First Name:	Initial:	Government Health Card Number #:
_____	_____	_____	|_|_|_|_|_|_|_|_|_|_|_|_|
Apt. Number:	Street Number & Name:	Home Telephone:	
_____	_____	( ) _____ _____	
City or Town:	Province:	Postal Code:	Occupation:
_____	_____	_____	_____

Marital Status: ☐ Single ☐ Married ☐ Other _____

Applicants Office Telephone: ( ) _____ _____	Co-Applicant's Office Telephone: ( ) _____ _____
Applicant's Fax: ( ) _____ _____	Co-Applicant's Fax: ( ) _____ _____
Applicant's Email: _____	Co-Applicant's Email: _____

If additional information is required during regular business hours, may we contact you by phone? ☐ Home ☐ Office

Are you now covered or did you have previous coverage with Manulife Financial? ☐ Yes ☐ No

If "Yes" Give Group and Identification Numbers: |_|_|_|_|_|_|_|_|_| |_|_|_|_|_|_|_|_|_|_|_|_|

Date Benefits ended? (dd/mm/yyyy): _____

Is this application intended to replace your current Manulife Financial coverage? ☐ Yes ☐ No

Have you been covered by any other health plan? ☐ Yes ☐ No

If Yes, Where? _____ Date benefits ended? _____

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Name: _____	Relationship to Applicant: _____

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed

Name of Trustee: _____	Relationship to Applicant: _____

Signature of Applicant:_____ Dated (dd/mm/yyyy): _____

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PART B – PLAN CHOICE

Remember: Your Plan Choice applies to all family members except Lifeline.

I / We apply for:

CORE PLANS	ADD-ONS	STAND-ALONES
	(Available only with a Core plan)	(Available without a Core plan)
☐ DentalPlus™ *Basic**	☐ Travel + 8days (Not available with Combo Plus*Starter*)	☐ Extended Health Care (EHC) *Basic*
☐ DentalPlus™ *Enhanced**	☐ Travel + 21days (Not available with Combo Plus*Starter*)	☐ Extended Health Care (EHC) *Enhanced*
☐ DrugPlus™ *Basic*	☐ Accidental Death & Dismemberment *Enhanced* *	☐ Hospital *Basic*
☐ DrugPlus™ *Enhanced*	☐ Extended Health Care *Enhanced*	☐ Hospital *Enhanced*
☐ ComboPlus™ *Starter**	☐ Hospital *Basic*	☐ Hospital *Cash*
☐ ComboPlus™ *Basic*	☐ Hospital *Enhanced*	☐ Catastrophic Coverage
☐ ComboPlus™ *Enhanced*	☐ Hospital *Cash*	
	☐ Catastrophic Coverage	
	☐ Vision *Enhanced* (Not available with Combo Plus*Starter*)	

* These plans do not require completion of the Medical Questionnaire of this application.

For Lifeline Personal Response Service, contact us and request a Lifeline application.

PART C – INDIVIDUALS TO BE COVERED

First Name	Last Name	Health Card No	Code	Sex	Birth date (dd/mm/yyyy)	Age	SMOKER? # of Cigarettes Daily
_____ APPLICANT	_____	|__|__|__|__|__|__|__|__|__|__|	00				
_____ CO-APPLICANT	_____	|__|__|__|__|__|__|__|__|__|__|	01				
_____ DEPENDANT CHILD	_____	|__|__|__|__|__|__|__|__|__|__|	02				
_____ DEPENDANT CHILD	_____	|__|__|__|__|__|__|__|__|__|__|	02				
_____ DEPENDANT CHILD	_____	|__|__|__|__|__|__|__|__|__|__|	02				
_____ DEPENDANT CHILD	_____	|__|__|__|__|__|__|__|__|__|__|	02				

If you require more space to complete any part of this application, please attach a separate sheet.

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PART C (cont'd) – INDIVIDUALS TO BE COVERED

	HEIGHT (cm/inch)	WEIGHT (lbs/kg)	WEIGHT CHANGE IN LAST YEAR GAIN	LOSS	REASON
APPLICANT:					
CO-APPLICANT:					
DEPENDANT CHILD:					
DEPENDANT CHILD:					
DEPENDANT CHILD:					
DEPENDANT CHILD:					

PART D – BILLING OPTIONS

Initial Payment: I hereby authorize Manulife Financial to debit the initial 2 months premium, $_____,
from my: ☐ Financial Services Account ☐ Credit Card Account

Subsequent Payments: Will be made by:

☐ **Pre-Authorized Payment Plan From my Financial Institution** (Please also complete PART E below)

PAP Billing Frequency: ☐ Monthly ☐ Semi-annually (2% Discount) ☐ Annually (4% Discount)

☐ **Credit Card** (Please also complete PART E below)

☐ Visa ☐ MasterCard ☐ Amex Account # _____ Expiry Date (mm/yyyy) _____

Cardholder:_____ Signature of Cardholder:_____
(if other than Applicant or Co-applicant)

Credit Card Billing Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

☐ **Direct Billing**

Direct Billing Frequency: ☐ Semi-annually (2% Discount) ☐ Annually (4% Discount)

Important: For verification purposes we require a VOID cheque if a payment is being withdrawn from your financial services account.

Please note: Premium discounts are not available for Credit Card payment options.

Manulife Financial will give me/us at least 30 days written notice in advance, should there be a change in either the amount or premium due date. Manulife Financial may terminate coverage if a withdrawal is refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 NSF fee will be charged for all NSF transactions.

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PART E – FINANCIAL INSTITUTION (FOR PRE-AUTHORIZED PAYMENT PLAN)

Name of account holder(s) if different from applicant: _____

Financial Institution: _____

Address: _____

City/Town: _____

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ Current ☐ Direct Deposit Account ☐ 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. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

For Pre-Authorized Payment and Credit Card billing options: I/We hereby authorize Manulife Financial to withdraw premium payments from my/our account on or about the first business day of the month. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

Manulife Financial will give me/us at least 30 days written notice in advance should there be a change in either the amount or premium due date. Manulife Financial may terminate coverage if a withdrawal is refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 NSF fee will be charged for all NSF transactions.

Signature of account holder:	_____
Second signature if joint account:	_____

MEDICAL QUESTIONNAIRE - PAGE 5

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence on the first of the month following approval of this application.

***All applicants must sign and complete the Applicant's Declaration.**

SECTION A – TREATING QUALIFIED HEALTH CARE PRACTITIONER

Must be completed for all plans except DentalPlus and ComboPlus Starter.

Name and Address of Present Primary HealthCare Provider/Physician (who holds the majority of your medical records) and any other Qualified Health Care Practitioners consulted (if none, print "none"):

	Applicant	Co-Applicant	Dependant(s)
Name of Primary Health Care Provider:			
Address of Primary Health Care Provider:			
Last Consultation Date:			
Reason:			
Diagnosis made:			
Treatment given:			
Name and Address of any other Qualified Health Care Practitioner consulted:			

SECTION B – PREFERRED UNDERWRITING QUESTIONNAIRE

Must be completed for all plans except DentalPlus and ComboPlus Starter

These questions are intended for streamlining applicants.

Have you, your co-applicant or any listed dependant:

1. Been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years? ☐ Yes ☐ No

2. Consulted or been advised to consult a Qualified Health Care Practitioner about or had any known indication of a medical condition within the last year? ☐ Yes ☐ No

3. Sustained any injury or been treated for any medical condition that requires or has required the services of a Qualified Health Care Practitioner at least once per year within the last 2 years? ☐ Yes ☐ No

4. a) Been advised to use a medication or treatment for a chronic and/or recurring medical condition;
   b) Used any medication or treatment for 20 or more days within the past year;
   c) Expect to use any medication or treatment within the next 3 months? ☐ Yes ☐ No
   Note: Medications used for birth control or to treat minor ailments like cold or flu are not to be considered "Yes" when answering this question.

5. Been diagnosed with any major medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? ☐ Yes ☐ No

Note: Additional medical information may be required to underwrite your application.

If any questions above are answered "Yes", please complete Sections C and D below.

MEDICAL QUESTIONNAIRE - PAGE 6

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence on the first month following approval of this application.

***All applicants must sign and complete the Applicant's Declaration.**

SECTION C – MEDICAL CONDITIONS

Must be completed for all plan choices except DentalPlus and ComboPlus Starter.

1. Have you, your co-applicant or any listed dependant ever consulted a Physician or Health Care Practitioner about, been treated for, or had any known indication of: (check yes or no to all questions)

a) High Blood Pressure, Stroke, T.I.A. or Chest Pain	☐ Yes ☐ No	i) Arthritis/Rheumatism	☐ Yes ☐ No
b) Heart, High Cholesterol or Circulatory Disorder, Dizziness, Fainting or Blood Disorder	☐ Yes ☐ No	j) Cancer, Tumor or any Growth	☐ Yes ☐ No
c) Back, Joint or Musculoskeletal Pain or Disorder	☐ Yes ☐ No	k) Skin Disorder	☐ Yes ☐ No
d) Digestive System Disorder, Liver Disease/Disorder including Hepatitis	☐ Yes ☐ No	1) Infertility/Reproductive Disorder/Menopause	☐ Yes ☐ No
e) Nervous, Mental, Emotional Disorder	☐ Yes ☐ No	m) Bladder/Kidney Disorder or other Genitourinary Disorder	☐ Yes ☐ No
f) Alcohol/Drug Abuse	☐ Yes ☐ No	n) Headaches/Migraines	☐ Yes ☐ No
g) Asthma/Allergies/Respiratory Disorder or Shortness of Breath	☐ Yes ☐ No	o) Diabetes/Endocrine Disorder	☐ Yes ☐ No
h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV)	☐ Yes ☐ No	p) Eye or Ear Disorder	☐ Yes ☐ No
		q) Other Condition/Disease/Disorder Please specify:_____	☐ Yes ☐ No

2. Have you, your co-applicant or any listed dependant ever been treated or hospitalized for any Physical Impairments, Congenital Abnormality, Medical Condition, Disease or Disorder not stated above?

Applicant: ☐ Yes ☐ No Co-applicant: ☐ Yes ☐ No Dependant Child: ☐ Yes ☐ No

3. Have you, your co-applicant or any listed dependant ever been advised to have an investigation, hospitalization or surgery which has not been completed? Applicant: ☐ Yes ☐ No Co-applicant: ☐ Yes ☐ No Dependant Child: ☐ Yes ☐ No

4. If answer is "yes" to any question in Section C, give explanation below:

Question No.	Proposed Insured with Condition	Name of Illness/Condition	Date Diagnosed	Duration	Name & Address of Qualified Health Care Practitioner and/or hospital providing treatment	Results of treatment & extent of recovery

MEDICAL QUESTIONNAIRE - PAGE 7

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence on the first month following approval of this application.

***All applicants must sign and complete the Applicant's Declaration.**

SECTION D – MEDICATIONS AND TREATMENTS

Must be completed for all plans except DentalPlus and CombPlus Starter

5. Are you, your co-applicant or any listed dependant currently using or expect to be using medication or serum in the next 3 months?

(v yes or no) ☐ Yes ☐ No If yes, provide details below:

Proposed insured	Name of the drug/ medication/serum/ treatment	Condition being treated	Strength and daily dosage of the drug / medication / serum	Monthly cost	Length of time on this drug / medication / serum/treatment

6. Are you, your co-applicant or any listed dependant pregnant? ☐ Yes ☐ No

If yes: Name_____ Due Date (dd/mm/yyyy): _____

Note: Additional medical information may be required to underwrite your application.

SECTION E – CATASTROPHIC MEDICAL QUESTIONNAIRE

Must complete sections A, B, C, D when applying for Catastrophic coverage
(Available either as an Add-On or Stand-Alone coverage)

1. Have you, your co-applicant or dependants, natural parents, brother(s), sister(s), either living or dead, ever suffered from any of the following conditions: Heart Disease, Stroke, Cancer (specify type), Diabetes, Kidney Disease, Mental Illness, Alcoholism, Huntington's Chorea, Amyotrophic Lateral Sclerosis (Louis Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's or any other hereditary disease? ☐ **Yes** ☐ **No**. **If yes, please complete the section below:**

Name of Proposed Insured	Relationship to Proposed Insured	Condition	Age at onset	Age if living	Age at death	Cause of death

2. **AVOCATION AND SPORTS**

Have you, your co-applicant or any listed dependant participated in the last 3 years or expect to participate in, any activities of a hazardous nature including, but not limited to: Motorized Vehicle Racing, Skin or scuba Diving, Sky Diving, Mountain Climbing, Hang-Gliding, or any other hazardous sports or activities? ☐ Yes ☐ No

If yes, please indicate the name of the avocation(s)/sport(s) and person to whom it applies:

_____

A supplemental questionnaire will be sent to you for completion.

3. Do you intend to fly other than as a passenger on a commercial airline, or have you flown other than as a passenger on a commercial airline within the past 3 years? ☐ Yes ☐ No

If yes, please indicate the name of the person to whom it applies:

_____

A supplemental questionnaire will be sent to you for completion.

4. **DRIVING RECORD**

Have you, your co-applicant or dependant in the last 3 years had your driver's license suspended, revoked or had 3 or more moving violations? ☐ Yes ☐ No

If yes, please provide:

Name: _____ Drivers License Number: _____

Details: _____

_____

_____

APPLICANT'S DECLARATION - All Applicants Must complete This Section

This Plan is underwritten by The Manufacturers Life Insurance Company.

☐ Check here if you do not wish to receive further information and material on Manulife Financial's products.

NOTE: THE INFORMATION PROVIDED ON THIS FORM IS CONSIDERED CONFIDENTIAL. The statements contained herein are true and complete and together with any other forms signed by me/us in connection with this application, form the basis for any Agreement issued hereunder. •If the plan I/we have selected is medically underwritten, I/we hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my/our health to release such information to Manulife Financial. I/We understand and agree that information relating to the administration of under this plan may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. •I/We understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the Agreement. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this Agreement. Manulife Financial reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. • I/We understand and agree that coverage shall not become effective until the first of the month following final approval. • Unless I/We have checked the box above, I/we consent to Manulife Financial providing me/us, from time to time, with further information and material regarding its products.

Signature of Applicant:_____ Signature of Co-applicant:_____

Dated:_____
(dd/mm/yyyy)