Manulife

MANULIFE Travel80 | TERM TRAVEL INSURANCE

Application Form

Certificate/File No.: _____

If you are scheduled for a medical procedure, except as part of a routine physical exam, you must receive the results of the medical procedure before you apply.
If you are 45 years of age or under and are eligible to purchase this insurance, you must complete sections 1, 2, 3, 9 and 10.
If you are 46 years of age or over, you must complete the entire application.
Travel80 is available to applicants at least 18 but not yet 66 years of age.

***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 ELIGIBILITY CRITERIA

Have you ever had or been treated for or are you currently being tested for: (Please check all applicable boxes)

- ☐ Chronic hepatitis or cirrhosis
- ☐ Alcohol or drug abuse, or its treatment in the last 5 years
- ☐ Cancer – all types except basal cell cancer
- ☐ Angina, heart attack, heart failure, or any heart surgery
- ☐ Huntington's disease
- ☐ Lou Gehrig's disease/amyotrophic lateral sclerosis (ALS)
- ☐ Major organ transplant or bone marrow transplant
- ☐ Muscular dystrophy
- ☐ Peripheral vascular disease
- ☐ Schizophrenia
- ☐ Transient ischemic attack (TIA) or mini stroke
- ☐ AIDS or AIDS-related disease/HIV
- ☐ Alzheimer's disease or dementia
- ☐ Chronic obstructive pulmonary disease (COPD), emphysema, pulmonary fibrosis, or any chronic lung condition
- ☐ Diabetes for which you have been prescribed medication
- ☐ Kidney disease including renal failure or dialysis but excluding kidney stones
- ☐ Lupus (lupus erythematosis)
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Permanent paralysis (paraplegia, quadriplegia, hemiplegia) – other than Bell's palsy
- ☐ Stroke – cerebrovascular accident
- ☐ Use or used, for a heart or lung condition, Coumadin, warfarin, Lasix, prednisone, oxygen or Nitroglycerine

You are not eligible for this insurance if you have checked any of the above boxes.

2 APPLICANT INFORMATION – Please print in ink

Last name		First name		☐ Male ☐ Female
Address	Unit no.	City	Province	Postal Code
Home telephone number		Business telephone number		Date of birth (DD/MM/YYYY)
Email				

3 SMOKER STATUS

Have you used any form of tobacco, tobacco cessation products or marijuana in the last 12 months?	☐ Yes ☐ No

4 HEIGHT AND WEIGHT

Height _____ ☐ m ☐ ft. _____ ☐ cm ☐ in. Weight _____ ☐ kg. ☐ lb.

5 REGULAR ATTENDING PHYSICIAN

Name and Specialty	Address	Telephone number

6 HEALTH DECLARATION

1. In the past 5 years, have you consulted a physician or other health care professional, or been admitted to any hospital or similar institution other than for routine physicals or minor conditions (such as colds, flu, etc.)?	☐ Yes ☐ No
2. Do you have any symptoms or health concerns for which you were advised to have further examinations, diagnostic tests (e.g., CT scan or MRI), hospitalization or surgery not yet done and/or for which test results are pending; which are under medical observation; or for which you have not yet consulted a physician or received treatment?	☐ Yes ☐ No
3. Are you currently under medical observation for any condition, or taking any medication?	☐ Yes ☐ No
4. Do you have or have you been treated for any disorders of: a. The heart or blood vessels, such as heart murmur, heart palpitations, heart disease, chest pain, circulatory problems, phlebitis, high blood pressure, high cholesterol or any other disorder of the heart or circulatory system?	☐ Yes ☐ No
b. The chest, lungs, nose, eyes, ears or throat, such as asthma, chronic bronchitis, sleep apnea, or any other lung or chronic respiratory disorder?	☐ Yes ☐ No
c. The digestive system, including stomach, intestines, colon, liver or pancreas, such as ulcer, colitis, bleeding or hepatitis, including hepatitis carrier state, or any other disorder of the digestive system?	☐ Yes ☐ No
d. The kidneys, bladder, reproductive organs or prostate, including sugar, blood, or protein in the urine, elevated PSA, or any other disorder of the genito-urinary system?	☐ Yes ☐ No
e. The nervous system, such as dizziness, numbness, tingling, loss of balance, weakness of the extremities, loss of speech, loss of sensation, paralysis, optic neuritis, visual disturbance, headaches, seizure, epilepsy, tremors, motor neuron disease, or any other disorder of the nervous system?	☐ Yes ☐ No
f. The blood or glandular system, such as diabetes, thyroid disorder, anemia, leukemia or any other disorder of the blood or glandular system?	☐ Yes ☐ No
g. The immune system, persistent lymph gland enlargement, allergies, unusual infections, or any other immune system abnormality?	☐ Yes ☐ No
h. The musculoskeletal system including rheumatism, arthritis, neuritis, fibromyalgia, back or neck pain, any form of chronic pain, osteoporosis, or any other disease or disorder of the bones, joints or muscles?	☐ Yes ☐ No
i. The breast, including lumps, cysts, unusual discharge, other physical changes, or abnormal test, finding or biopsy?	☐ Yes ☐ No
j. A tumorous nature or any other form of malignant disease including any cancer, tumour, polyp, cyst, mole, lump or other growth, or any disorder of the lymph glands?	☐ Yes ☐ No
k. A mental or nervous nature (such as depression, anxiety, stress, burnout, fatigue), or addiction (alcohol, drug or any other addiction); have you been advised to reduce alcohol or drug use; or have you used drugs for other than prescribed medical purposes?	☐ Yes ☐ No

7 IF YOU ANSWERED "YES" TO ANY QUESTION IN SECTION 6, GIVE DETAILS BELOW:

QUESTION NUMBER AND PART (e.g., 4b)	INCLUDE ALL INFORMATION APPLICABLE TO MEDICAL CONDITION OR SITUATION	DATES OF DIAGNOSIS OR ONSET AND DURATION	RESULT AND CURRENT STATUS	NAME AND ADDRESS OF PHYSICIAN OR HOSPITAL

8 FAMILY HISTORY

Have any of your immediate family members (father, mother, brothers or sisters) had heart disease, stroke, aneurysm, cancer (specify type), diabetes, kidney disease, multiple sclerosis, Parkinson's disease, ALS, Alzheimer's disease, motor neuron disease or any other hereditary disorder?*	☐ Yes ☐ No

FAMILY MEMBER	CONDITION (IF CANCER, SPECIFY TYPE)	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH AND CAUSE

9 PAYMENT METHOD

PAYMENT OPTION: ☐ MONTHLY ☐ ANNUAL

☐ VISA ☐ MASTERCARD ☐ AMEX ☐ CHEQUE

CREDIT CARD NUMBER_____EXPIRY DATE (MM/YYYY)_____

PAYMENT AUTHORIZATION

For credit card and pre-authorized payment billing options – I/We hereby authorize Manulife to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This authorization may be terminated by either Manulife or by me/us through written notice. Manulife will terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

NAME OF CARDHOLDER OR ACCOUNT HOLDER

SECOND NAME IF JOINT ACCOUNT

SIGNATURE OF ACCOUNT HOLDER

SECOND SIGNATURE IF JOINT ACCOUNT

10 TERMS AND CONDITIONS (Please read carefully before signing)

I hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

I declare that the statements contained in this application, including the Health Declaration attached hereto, are true and complete. I declare that I am resident in Canada and at least 18 but not yet 66 years of age. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any policy issued hereunder. I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I understand that exclusions and limitations apply to the coverage applied for. Relative to the insurance applied for, I, the person to be insured, hereby authorize any licensed physician, hospital, other medical service provider or any other organization or person that has any records or knowledge of me or my health status to release to the assistance and claims service provider, appointed by Manulife, any such information for the purpose of underwriting and administering the contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose.

I declare that I have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. This consent shall take effect on the date of signing of this application and shall expire seven (7) years after the termination date of any policy issued as a result of this application. I understand that this consent may be revoked at any time and that if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

Insurance will take effect on the first of the month following the date the properly completed application (including my properly completed Health Declaration) and the first year's premium is received by Manulife and subject to the approval of the Company's underwriters. I understand that any health information must be accurate as at the date this application is signed. If I am approved, I will receive a policy specifying the coverage provided. If I am not insurable, a full refund of the premiums will be made.

A photocopy or faxed copy of this authorization shall be as valid as the original. I acknowledge receipt of the Notice on Privacy and Confidentiality.

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

IMPORTANT INFORMATION

Your Manulife Travel80 Term Travel Insurance policy has a number of limitations and exclusions. We would like to remind you that your policy does not cover expenses resulting from or related to:

- **A heart condition if, in the three (3) months before your departure date, you have taken any form of nitroglycerine for the relief of angina pain for your heart condition.**
- **A lung condition if, in the three (3) months before your departure date, you required treatment, or were treated, with oxygen or prednisone for your lung condition.**
- **Any of the following medical conditions or symptoms that lead to a diagnosis of such condition: Heart condition • Lung condition • Stroke/CVA or mini stroke/TIA • Diabetes treated with medication • Peripheral vascular disease • Tumor or cancer of all types except basal and squamous cell cancer • Chronic bowel disorder, diverticular disorder, bowel obstruction or surgery • Gastrointestinal bleeding, bleeding ulcer, perforated ulcer • Gall bladder disorder • Liver, kidney, bladder, prostate or reproductive system disorder • Pancreatitis • Aneurysm • Blood disorder • Organ transplant • Multiple sclerosis • Parkinsons.**

If, in the three (3) months prior to your departure date:

- **° you have had new symptoms, and existing symptoms have become more frequent or more severe or there have been test results showing deterioration; and/or**
- **° a physician has determined that the condition has become worse; and/or**
- **° you have been prescribed or received a recommendation for a new prescription medication or change in medication dosage or frequency. Exceptions: routine adjustment of Coumadin, warfarin, insulin or oral medication to control diabetes (as long as they are not new or stopped prescriptions); change from a brand name to equivalent generic drug of the same dosage; and/or**
- **° you have been prescribed or received a recommendation for a change in treatment for that condition; and/or**
- **° you have been admitted to a hospital and/or you are awaiting results of further investigation for that medical condition.**
- **Any medical condition:**
  - **° for which you required surgical intervention in the three (3) months prior to your departure date; and/or**
  - **° if it was reasonable to expect before you left home that you could need treatment during your trip; and/or**
  - **° when you knew, before you left home, or before the departure date, that you would need or be required to seek treatment for that medical condition; and/or**
  - **° symptom for which future investigation or treatment was recommended and/or planned before you left home; and/or**
  - **° when you have taken your trip with the expectation of seeking treatment whether or not it was recommended or authorized by a physician; and/or**
  - **° that had caused your physician to advise you not to travel.**

Les parties ont expressément demandé que la présente entente et les annexes ou document y afférents soient rédigés en anglais. The parties have expressly requested that this agreement and any related appendices or documents be drafted in the English language.

SIGNED AT | DATE (DD/MM/YYYY) | SIGNATURE OF APPLICANT

RETURN THIS APPLICATION FORM WITH YOUR PREMIUM PAYMENT TO YOUR BROKER/ADVISOR OR MAIL OR FAX TO:

Manulife Travel80 Term Travel Insurance
P.O. Box 4262, Stn A Toronto, ON M5W 5T4

Fax 1 888 264-2243
416 687-5143

AGENT/ADVISOR'S REPORT

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent
- that you receive commissions for the sale of life, accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last)	Advisor code	Signature x

11 AGENT – Please complete this section

Agent name	Telephone number	Fax number	Agent Selling Code
Company name and address	**Email address**		**Resource Selling Code**

Travel80™ Term Travel Insurance is currently not available to residents of Quebec or New Brunswick.

Manulife

Plans underwritten by
The Manufacturers Life Insurance Company (Manulife)
and First North American Insurance Company (FNAIC), a wholly owned subsidiary of Manulife.