Manulife

Agent Name
Lori Yorke

Flexcare® Plans

Agent ID	Logo ID
MB1066	

Health and Dental Application

WSE

All applicants must complete Parts A, B, C and D. All applicants must complete and sign Applicant's Authorization and Declaration.

All applicants must have coverage under a Canadian provincial/territorial health care insurance plan in order to be eligible for this insurance product. If anyone on the application does not meet this requirement, please contact our Customer Service for more information.

When you apply for insurance, your beneficiary is set as your estate. To change this, please log into SecureServe at manulife.ca/secureserve.

Part A – General Information

Primary Applicant

Last Name First Name Initial

Does each applicant have provincial/territorial health care coverage? ☐ Yes ☐ No

Home Address Unit/Apt. City Province Postal Code

Home Telephone Office Telephone

Email (optional)

If additional information is required, how may we contact you? ☐ Home ☐ Office ☐ Email

Co-Applicant

Last Name First Name

Telephone Email (optional)

If additional information is required, how may we contact you? ☐ Telephone ☐ Email

Are you now covered by or did you recently have employer group health insurance coverage? ☐ Yes ☐ No

If yes, please indicate:

Primary Applicant

Group Plan Number ID Number

Insurance Company Date Benefits Ended DD/MM/YYYY

Co-Applicant

Group Plan Number ID Number

Insurance Company Date Benefits Ended DD/MM/YYYY

Note for Quebec residents:

Is this application intended to replace current coverage other than your current or recently ended group health plan? ☐ Yes ☐ No

If you intend to replace coverage other than your current or recently ended group health plan, do not cancel your existing coverage. Manulife may not be able to issue a policy where replacement of an existing insurance product is intended. The prescription drug coverage available under this plan is limited to costs not covered by the RAMQ Prescription Drug Insurance Plan. It is not intended to be a replacement for the RAMQ Plan. In order to be eligible for coverage under this plan, you must have a provincial health card and be registered under the RAMQ Prescription Drug Insurance Plan, or have equivalent coverage under a group plan.

Part B – Plan Choice

Remember: Your plan choice applies to all family members.

I/We apply for:

Core Plans

- ☐ DrugPlus™ *Basic*
- ☐ DrugPlus *Enhanced*
- ☐ DentalPlus™ *Basic*†
- ☐ DentalPlus *Enhanced*†
- ☐ ComboPlus™ *Starter*†
- ☐ ComboPlus *Basic*
- ☐ ComboPlus *Enhanced*

Add-Ons – Available only with a Core Plan

- ☐ Travel *+8 days*†[3]
- ☐ Travel *+21 days*†[3]
- ☐ Accidental Death & Dismemberment *Enhanced*†
- ☐ Hospital *Basic*
- ☐ Hospital *Enhanced*
- ☐ Catastrophic Coverage[2] ($4,500 threshold)
- ☐ Catastrophic Coverage[2] ($10,200 threshold)
- ☐ Vision *Enhanced*†[1]

Stand-Alones – Available without a Core Plan

- ☐ Hospital *Basic*
- ☐ Hospital *Enhanced*
- ☐ Catastrophic Coverage ($4,500 threshold)
- ☐ Catastrophic Coverage ($10,200 threshold)

☐ **Manulife *Vitality*™**: Helps you live healthier, earn rewards and save money.
Add it to your plan and automatically save 5% on your Flexcare premiums in your first year.
(Available for Primary Applicant only).

† These plans do not require completion of the Medical Questionnaire in this application.
[1] Not available with the ComboPlus™ Starter plan.
[2] Only available with the DrugPlus™ and ComboPlus™ Plans (not available to persons age 65 and over).
[3] Travel coverage ceases at age 70.

Part C – Individuals to be Covered

Last Name	First Name	Code	Sex	Birth date DD/MM/YYYY	Age	Smoker? No. of Cigarettes Daily	Height inch/cm ☐ ☐	Weight lbs/kg ☐ ☐	Weight change in last year gain	loss	Reason for weight change
Applicant		00									
Co-applicant		01									
Dependant		02									
Dependant		02									
Dependant		02									
Dependant		02									

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

Part D – Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, $, using my/our:

☐ Pre-Authorized Debit (PAD)

Important: Initial payment will be taken on the **day approved** (not the effective date). Future payments will be taken on the first of each month.
To apply securely using your credit card, please contact your advisor.

Subsequent payments will be made by:

Option #1 ☐ Pre-Authorized Debit (PAD)

PAD Billing Frequency: ☐ Monthly ☐ Semi-Annual (2% savings) ☐ Annual (4% savings)

Important: For verification purposes, we require a sample cheque marked 'VOID'.

Option #2 ☐ Direct Billing

Direct Billing Frequency: ☐ Semi-Annual (2% savings) ☐ Annual (4% savings)

Pre-Authorized Debit (PAD) Payment Information

Please use the following banking information:

☐ From the cheque used to make the first payment **or**

☐ As follows (only complete the information below if you do not have a void cheque):

Name of Account Holder

Transit Number Institution Number Bank Account Number

Financial Institution Address of Account Holder

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.

Pre-Authorized Debit (PAD) Payment Authorization

I/We hereby authorize Manulife to make a withdrawal from my/our bank account on the day on which insurance premiums are due for insurance premiums due on or after I/we sign this authorization.

Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account. If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by Payments Canada in Rule H-1.

I/We or Manulife may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-268-3763 or more_info@manulife.ca, or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a reimbursement claim, or for more information on your recourse rights, contact your financial institution or visit www.payments.ca.

Signature of Account Holder _____ Dated DD/MM/YYYY

Second Signature if Joint Account _____ Dated DD/MM/YYYY

Account Holder Address (if different from Applicant)

Part E – Medical Questionnaire

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 no earlier than the first of the month following final approval of this application and receipt of first premium payment.

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

Additional medical information may be required to underwrite your application. If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

Pre-existing Illness Or Conditions Ineligible for Coverage

Please note this is a partial list of the most common ineligible conditions and there may be other conditions ineligible for coverage.

- pending investigations, tests or surgery
- heart attack, angina, stroke, atrial fibrillation
- coronary artery disease, peripheral vascular disease, aneurysm
- angioplasty or coronary artery bypass grafting
- diabetes diagnosed prior to age 50 (excluding gestational diabetes fully resolved)
- cancer diagnosed and/or treated within the last ten years
- anxiety, depression or mood disorder with recent treatment initiated or dosage change; recent hospitalization or time off work
- Alzheimer's disease, dementia, Parkinson's, multiple sclerosis
- Huntington's disease, muscular dystrophy
- AIDs or HIV positive
- Down's syndrome, cerebral palsy, cystic fibrosis, spina bifida
- Drug/alcohol abuse within last five years

Medical Declaration

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

1. Name of physician or health care worker who holds the majority of your medical records:

   Applicant:

   Co-Applicant:

   Children:

   Provide the date and reason you, your co-applicant and your children last consulted with a physician or health care worker, including walk-in clinic or tele-health consultations:

   Applicant:

   Co-Applicant:

   Children:

Medical Declaration (continued)

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

IMPORTANT: Any reference to testing, tests, test results, or investigations in this section 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.

	Applicant		Co-Applicant		Child(ren)	
	YES	NO	YES	NO	YES	NO
2. Do you have any symptoms or concerns for which you have not yet consulted a doctor or health care worker?	☐	☐	☐	☐	☐	☐
3. In the **last 5 years**, have you, your co-applicant or children:						
a) had any doctor or health care worker recommend any tests, treatment, examination, surgery (including day surgery), hospitalization, or referrals that have not been completed or are you, your co-applicant or children currently awaiting test results?	☐	☐	☐	☐	☐	☐
b) been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks?	☐	☐	☐	☐	☐	☐
4. Are you currently using any prescribed medication, medical equipment or testing device or do you expect to do so in the **next 3 months** (exclude birth control, medication for cold or flu)?	☐	☐	☐	☐	☐	☐
5. For the following questions have you, your co-applicant or children ever had any consultation with any doctor or health care worker about:						
a) High blood pressure or high cholesterol?	☐	☐	☐	☐	☐	☐
b) Heart attack, stroke, transient ischemic attack (TIA), chest pain, or other heart or circulatory disease or disorder?	☐	☐	☐	☐	☐	☐
c) Chronic pain, any back, joint or musculoskeletal pain or disorder, fibromyalgia, gout, arthritis, rheumatoid arthritis, lupus, scleroderma, osteopenia/osteoporosis, or paralysis, weakness or numbness?	☐	☐	☐	☐	☐	☐
d) Crohn's disease, colitis, ulcerative colitis, irritable bowel disorder, acid reflux, cirrhosis, hepatitis including carrier state, or other stomach, bowel, pancreas or liver disorder?	☐	☐	☐	☐	☐	☐
e) Depression, anxiety, stress, sleep disorder, attention deficit disorder (ADD), eating disorder, autism or any other psychological or emotional disorder?	☐	☐	☐	☐	☐	☐
f) Epilepsy, multiple sclerosis, Alzheimer's disease, dementia, Parkinson's disease, or any other nervous system disease or disorder?	☐	☐	☐	☐	☐	☐
g) Headaches or migraines?	☐	☐	☐	☐	☐	☐
h) Alcohol or drug abuse, or any addiction?	☐	☐	☐	☐	☐	☐
i) Allergies, asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or other respiratory disease or disorder?	☐	☐	☐	☐	☐	☐
j) Testing or treatment (including prophylactic treatment), for AIDS or HIV (exclude routine negative testing for pregnancy, blood donation, immigration or insurance)?	☐	☐	☐	☐	☐	☐
k) Cancer, tumor, leukemia or lymphoma, or any cyst(s) or growth(s)?	☐	☐	☐	☐	☐	☐
l) Acne, rosacea, eczema, psoriasis, or other skin disease or disorder?	☐	☐	☐	☐	☐	☐
m) Infertility or assisted conception, polycystic ovary syndrome (PCOS), or other breast or reproductive disorder?	☐	☐	☐	☐	☐	☐
n) Kidney disease or disorder, interstitial cystitis or other bladder disorder, benign prostatic hyperplasia or other prostate disorder, genital herpes or any other sexually transmitted diseases or infections (STDs or STIs)?	☐	☐	☐	☐	☐	☐
o) Diabetes or elevated blood sugar, hyperthyroid, hypothyroid, pituitary disorder, or other endocrine disease or disorder?	☐	☐	☐	☐	☐	☐
p) Cataract(s), glaucoma, loss of vision, impaired hearing, tinnitus, any balance disorder, or other eye or ear disease or disorder?	☐	☐	☐	☐	☐	☐
6. Are you or your co-applicant currently pregnant?	☐	☐	☐	☐		
If yes, have you or your co-applicant ever experienced complications with current or any prior pregnancy?	☐	☐	☐	☐		

Please provide the expected delivery date: DD/MM/YYYY and pre-pregnancy weight (include lb. or kg.):

If you have answered yes to any of these questions, please provide full details below:

Person to be insured	Question	Details, diagnosis if known, treatment history, testing dates, reason for tests, results of tests, recurrence and names of all attending doctors.

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

Catastrophic Coverage Medical Questionnaire

Must also complete Sections A and C when applying for the Catastrophic Coverage Rider (available as an add-on).

1. Have you, your co-applicant or any listed dependant(s), natural parents, brother(s), sister(s), either living or dead, ever suffered from any of the following conditions: heart disease, stroke, cancer (specific type), Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis or retinitis pigmentosa? ☐ Yes ☐ No

   If yes, please complete the section below.

Name of Individual	Relationship to Proposed Insured	Condition	Age at Onset	Age at Death	Cause of Death

2. Have you, your co-applicant or any children in the last 2 years flown as a private pilot, or participated in any activities of a hazardous nature, such as motor vehicle racing, skin or scuba diving, sky diving, mountain climbing, hang-gliding, or do you expect to participate in the next 12 months? ☐ Yes ☐ No

   If yes, please indicate the name of the activity and person participating.

   A supplemental questionnaire may be sent to you for completion.

3. Have you, your co-applicant or any children in the last 2 years had your driver's licence suspended, revoked or been convicted of 3 or more moving violations? ☐ Yes ☐ No

   If yes, please provide full details including the date and reason licence was suspended or revoked and date reinstated.
   Also include the kilometres over for each moving violation and the date of each violation.

   A supplemental questionnaire may be sent to you for completion.

Personal Information Statement

In this Statement, "you" and "your" refer to the plan member or holder of rights under the contract, the insured and the parent or guardian of any child named as insured who is under the legal age for providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you such as:

- Identifying information such as your name, address, telephone number(s), email address, date of birth, or driver's licence
- Medical information that any organization or person has about you
- A copy of all driving-related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or consumer report from other organizations, persons or sources that have any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking data to administer benefits
- Other personal information we may require to administer our business relationship with you

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

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company,
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your plan now, and in the future
  - Public sources, such as government agencies, and Internet sites
  - Health care professionals, including medical practitioners, health care institutions, pharmacies and any other medically related facilities
  - Other insurance carriers
  - Administrators of government benefits and other benefit programs

What do we use your personal information for?

We will use your personal information to:

- Help us properly 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, and issue and administer the rights under the plan
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons and other parties with whom we deal in issuing and administering your plan now, and in the future
- Authorized employees, agents and representatives
- 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 medical doctor

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be 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.

How long do we keep your information?

The longer of:

- The time period required by law and by guidelines set for the financial services industry, and
- The time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the plan unless federal or provincial laws give you this right. If you do so, a plan may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care centre at 1-877-268-3763, or write to the Privacy Officer at the address below.

Accuracy and access

You will notify us of any change to your contact information. 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. If you have a question, a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
P.O. Box 1602
500 King Street North
Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Applicant's Authorization and Declaration

All applicants must complete this section.

I/We hereby acknowledge that 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 policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with Manulife's Personal Information Statement. I/We understand and agree that coverage shall not become effective until the first of the month following final approval and receipt of the first premium payment.

A photocopy of this signed authorization shall be as valid as the original.

Signature of Applicant _____ Signed at City, Province Date DD/MM/YYYY

Signature of Co-Applicant _____ Signed at City, Province Date DD/MM/YYYY

Advisor's report • For Advisor Use Only

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
Lori Yorke	MB1066	

Please send the completed application to:

Regular Mail:
Manulife
P.O. Box 670
Stn Waterloo
Waterloo, ON N2J 4B8

Courier:
Manulife
500 King Street
Affinity Markets New Business
Delivery Station 500-GB
Waterloo, ON N2J 4C6

Note: If you are contracted through a MGA/National Account firm, please forward the completed application to their office.

For more information visit **Manulife.ca** or speak to your advisor.
To speak with a Manulife representative, contact **1-888-626-8543**.

Manulife

Flexcare® is offered through **The Manufacturers Life Insurance Company (Manulife).**

The Vitality Group Inc., in association with The Manufacturers Life Insurance Company, provides the Manulife *Vitality* program.
Vitality is a trademark of Vitality Group International, Inc., and is used by The Manufacturers Life Insurance Company and its affiliates under license.

Manulife, Manulife & Stylized M Design, Stylized M Design, Flexcare and ComboPlus are trademarks of The Manufacturers Life Insurance Company and are used by it and by its affiliates under license.
© 2021 The Manufacturers Life Insurance Company. All rights reserved.
Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.
Accessible formats and communication supports are available upon request. Visit **manulife.ca/accessibility** for more information.

21_143237 12/2020 AC AF1344E