



Application for Insurance

Please print clearly

Client No.

Policy No.

Section 1 Employee Information

Name of Employee			<input type="checkbox"/> Male
			<input type="checkbox"/> Female
Date of Birth (yyyy/mm/dd)	Place of Birth (City and Country)	Height (ft./in.)	Weight (lbs.)
Employee's Address			
Telephone Number (Residence)		(Business)	
Employer's Name and Address			
Regular Physician or Family Doctor Name and Address			
Date and Reason Doctor Last Seen			

Section 2 Applicant Questions

Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application.

	Yes	No
1. Have you had any indication of, or been treated for:		
a. any disease or disorder of the eyes, ears, nose, mouth or throat, or any allergies including any job-site environmental sensitivity?	<input type="checkbox"/>	<input type="checkbox"/>
b. lung trouble, pneumonia, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. dizziness, fainting, convulsions, headaches, migraines, paralysis or stroke, epilepsy, chronic anxiety, burnout, fatigue, depression, or eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. chest pains, palpitations, high blood pressure, phlebitis, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e. hepatitis, ulcer, hernia, appendicitis, colitis, Crohn's, diverticulitis, hemorrhoids, recurrent indigestion or other disorders of the stomach, intestine, liver or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>
f. sugar, albumin, protein, blood and/or pus in the urine, sexually transmitted disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
g. any hereditary disorders or diabetes, thyroid, or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
h. gout, neuritis, sciatica, rheumatism, arthritis, fibromyalgia, disorder of the muscles or bones, including the spine, back or joints?	<input type="checkbox"/>	<input type="checkbox"/>
i. disorder of the skin, breasts, lymph glands, cysts, tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
j. anemia, or other disorder of the blood or have you ever received a blood transfusion or blood products?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever used or dealt in barbiturates, narcotics, or other drugs or hallucinogens, including marijuana and cocaine, except as prescribed by a physician or received or been advised to receive or currently receiving treatment or counseling for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any driving infractions within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever tested positive for, been diagnosed with, or told you have Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) disease?	<input type="checkbox"/>	<input type="checkbox"/>

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Section 2 Applicant Questions (continued)

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Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application.

	Yes	No
5. Do you participate in organized contact sports or hazardous activities (e.g. mountain climbing, hang gliding, scuba-diving, parachuting, flying (pilot/crew member), motorized racing)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you contemplate a trip or taking up residence outside Canada or the USA? (Specify location and duration below).	<input type="checkbox"/>	<input type="checkbox"/>
7. Has any application for insurance been rated for higher premium, modified, postponed, declined or rescinded?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you currently unable to work, whether inside or outside the home? How many work days have you lost due to disability/illness in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
9. Other than above, have you within the last five years:		
a. been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>
b. received medical or surgical attention due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
c. been a patient in a hospital, clinic, sanitarium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. had an electrocardiogram, x-ray, or other diagnostic tests with abnormal findings or indicating any health problems?	<input type="checkbox"/>	<input type="checkbox"/>
e. sought any alternative medical treatment, such as Naturopathy, Acupuncture, Chiropractic care, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
f. requested or received a pension, benefits or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you currently pregnant? If so, due date:	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you used any form of tobacco or cannabis in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3 For every "Yes" answer given above, please provide full details

Question No.	Nature of disorder	Date of first occurrence	Current status and treatment

Section 4 Declaration and Authorization

I declare that the information in this application is true and complete to the best of my knowledge, and, along with any other forms signed by me for this application, forms the basis for any insurance issued. In the event that I have provided my Social Insurance Number ("SIN"), then, upon approval of this application, I authorize the use of my SIN for the purposes of identification, tax reporting and the administration of my group benefits.

I authorize my employer or plan sponsor and Manulife Financial, its affiliates, subsidiaries, their authorized employees or service providers including, but not limited to, the Medical Information Bureau, reinsurers, any health care professionals or health or social service establishments, or other organization, institution or person who has knowledge of me, or my health, to collect, use, exchange, or share with or disclose to each other my personal information, solely for the purpose of underwriting, issuing, administering, and managing my group benefits plan in the course of daily operations. I hereby authorize Manulife Financial, in its discretion, to share any of my health information with my physician.

I understand that Manulife Financial, its affiliates, subsidiaries, their employees and service providers are subject to strict standards and policies to ensure that my personal information is secure and remains confidential. I understand that Manulife Financial does not sell, lease, or trade personal information, and that any personal information collected by Manulife Financial will be kept strictly confidential and is to be used by authorized individuals only. Authorized individuals include employees, agents, or representatives of Manulife Financial in the performance of their job, persons whom I have authorized, or persons permitted by law to use my personal information. I understand that I have the right to request and receive a copy of my personal information maintained by Manulife Financial at any time. However, I also acknowledge that where medical information has been provided to Manulife Financial through a third party, Manulife Financial will release that information to me only through my physician.

With respect to the release of medical information as requested by Manulife Financial, my doctor should consider that a reproduction of this consent is as valid as the original.

Signature	Date (yyyy/mm/dd)

Please sign here