

Flexcare Application – Page 2

***All applicants must complete parts A, B, C, D**

***All applicants must complete and sign the Applicant’s Declaration**

PART D • PAYMENT OPTIONS

Initial Payment

I/We hereby authorize Manulife Financial to debit the initial two (2) months premium, \$ _____ from my/our:

Option #1 Financial Services Account (Pre-Authorized Collection)

Option #2 Credit Card Account

Subsequent Payments will be made by:

Option #1 Pre-Authorized Collection (PAC) Plan from my Financial Services Account
PAC Billing Frequency: Monthly Semi-Annually (2% discount) Annually (4% discount)
Important: for verification purposes, we require a sample cheque marked 'VOID'. Please complete Part E.

Option #2 Credit Card Account
Credit Card Billing Frequency: Monthly Semi-Annually Annually
Please note: billing frequency discounts are not available for credit card payment options. Please complete Part E.

Option #3 Direct Billing
Direct Billing Frequency: Semi-Annually (2% discount) Annually (4% discount)

PART E • PAYMENT INFORMATION and AUTHORIZATION

For Pre-Authorized Collection (PAC) Options

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.

For Credit Card Payment Options

Credit Card: Visa MasterCard AMEX

Account Number _____ Expiry Date (mm/yyyy) _____

Name of Cardholder _____ Signature of Cardholder _____

(if other than Application or Co-Applicant)

Payment Authorization

For Pre-Authorized Payment and Credit Card billing options: I/We hereby authorize Manulife Financial 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 Financial or by me/us through written notice.

Manulife Financial may 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.

Signature of Cardholder or Account holder _____ Second signature if joint account _____

SECTION A • TREATING QUALIFIED HEALTH CARE PRACTITIONER

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

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

Primary Health Care Provider	For Applicant	For Co-Applicant	For Dependand(s)
Name of Primary Health Care Provider			
Address of Primary Health Care Provider			
Date of last consultation			
Reason for last consultation			
Diagnosis made			
Treatment given			

Name and Address of any other Qualified Health Care Practitioner consulted _____

Date and Reason for Consultation _____

To which individual applying for coverage does this apply? _____

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

Flexcare Medical Questionnaire – Page 3

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.

***All applicants must complete and sign the Applicant’s Declaration**

SECTION B • SIMPLIFIED UNDERWRITING QUESTIONNAIRE

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

Additional medical information may be required to underwrite your application.

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; Yes No
 b) Used any medication or treatment for 20 or more days within the past year; Yes No
 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 medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? (Do not include any minor ailments such as the cold or flu.) Yes No

If any questions above are answered “Yes”, please complete section C below.

SECTION C • MEDICAL DECLARATION

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

Additional medical information may be required to underwrite your application.

- 1. Have you, your co-applicant or any listed dependant ever consulted a Physician or Qualified Health Care Practitioner about, been treated for, or had any known indication of: (✓ “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 any Musculoskeletal Pain or Disorder Yes No
 - k) Skin Disorder Yes No
 - d) Digestive System Disorder, Liver Disease/ Disorder including Hepatitis Yes No
 - l) Infertility/Reproductive Disorder/Menopause Yes No
 - e) Nervous, Mental, Emotional or Stress 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 Yes No

Please specify _____
- 2. Have you, your co-applicant or any listed dependant ever been treated for, hospitalized or had any known Physical Impairments, Congenital Abnormality, Medical Condition, Disease or Disorder **not stated above**? Applicant Yes No Co-Applicant Yes No Dependant 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 Yes No
- 4. If answer is “Yes” to questions 1 to 3 of Section C, please give explanation below:

Question No.	Name of individual with condition	Illness / condition / diagnosis	Date diagnosed	Duration	Name and address of Qualified Health Care Practitioner and/or hospital providing treatment	Current status of condition

- 5. Are you, your co-applicant or any listed dependant currently using or expect to use in the next 3 months any drug, medication, serum or other treatment? Yes No
 If “Yes”, provide details below:

Name of Individual	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 of pregnant individual _____ Due Date (dd/mm/yyyy) _____

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

Flexcare Medical Questionnaire – Page 4

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.

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

SECTION D • CATASTROPHIC MEDICAL QUESTIONNAIRE

Must also complete Sections A, B, C when applying for Catastrophic Coverage

(Available either as an Add-On or Stand-Alone coverage)

1. Have you, your co-applicant or any listed dependant, 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 (Lou 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 Individual	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, your co-applicant or any listed dependant, intend to fly other than as a passenger on a commercial airline, or have 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 this applies: _____
 A supplemental questionnaire will be sent to you for completion.

4. Driving Record

Have you, your co-applicant or any listed dependant in the last 3 years had your drivers licence suspended, revoked or had 3 or more moving violations? Yes No

If "Yes", please provide:
 Name _____ Drivers Licence Number _____
 Details _____

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 and 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
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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.

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 Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial 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 Financial 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 the Notice on Privacy and Confidentiality and the Notice on Information provided to the AIR MILES® Reward Program. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

Signature of Applicant _____ Signed at: _____

Signature of Co-Applicant _____ Dated (dd/mm/yyyy) _____

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

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