APPLICATION FORM
Health & Dental Insurance Plan for The McLennan Group

All Applicants must complete **Parts A, B, C, D and E** and **Section A** of the Application Form. **All Applicants** must complete and sign the **Declaration and Authorization** section.

The Manufacturers Life Insurance Company

WSG

Agent Id: 04402
LOGO ID:

TMG.HD.APP.E (04/17) 170127

Part A • General Information

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

NOTE: All applicants must have coverage under a 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 Manulife at **1-866-795-7285** for more information.

APPLICANT'S INFORMATION

Last Name _____

First Name _____ Initial ____

Business Telephone _____ Fax _____

Email _____

CO-APPLICANT'S INFORMATION

Last Name _____

First Name _____ Initial ____

Business Telephone _____ Fax _____

Email _____

APPLICANT'S ADDRESS

Address _____ City _____

Province _____ Postal Code _____ Home Telephone _____

If additional information is required, how may we contact you? ☐ Email ☐ Home ☐ Business Best time to call _____ ☐ AM ☐ PM

Are you now covered or did you previously have health insurance coverage with Manulife or any other insurance company? ☐ Yes ☐ No If yes, please indicate:

Plan Number _____ ID Number _____ Insurance Company _____ Date Benefits Ended _____ (DD / MM / YYYY)

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 • Beneficiary Designation

APPLICANT'S BENEFICIARY

☐ I hereby designate the individual(s) named as beneficiary(ies) for payment of the Accidental Death & Dismemberment benefit. In case of death, if no beneficiary is designated, benefits will be payable to the Estate.

Last Name _____

First Name _____ Relationship to Applicant _____

CO-APPLICANT'S BENEFICIARY

☐ I hereby designate the individual(s) named as beneficiary(ies) for payment of the Accidental Death & Dismemberment benefit. In case of death, if no beneficiary is designated, benefits will be payable to the Estate.

Last Name _____

First Name _____ Relationship to Co-Applicant _____

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a Trustee is appointed. By appointing a Trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

TRUSTEE:

Last Name _____

First Name _____ Relationship to Beneficiary _____

TRUSTEE:

Last Name _____

First Name _____ Relationship to Beneficiary _____

FOR QUEBEC RESIDENTS ONLY:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

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Part C • Plan Choice

I/We apply for the following Plan - Note: Your Plan Choice applies to all your family members.

☐ **Base Plan*** ☐ **Base Dental Plan*** ☐ **Bronze Plan** ☐ **Bronze Dental Plan*** ☐ **Silver Plan** ☐ **Silver Dental Plan*** ☐ **Gold Plan** ☐ **Gold Dental Plan***

* These plans do not require completion of Sections B, C and D of the Medical Questionnaire of this application.

Part D • Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, $ _____ , using my/our:
Option #1 ☐ Financial Institution Account **Option #2** ☐ Credit Card Account

SUBSEQUENT PAYMENTS:

Option #1 ☐ Pre-Authorized Debit (PAD) from my Financial Institution Account. *Please read and sign PART E below.*
Billing Frequency: ☐ Monthly ☐ Semi-Annual (2% discount) ☐ Annual (4% discount)
Important: For verification purposes, we require a sample cheque marked 'VOID'.

Option #2 ☐ Credit Card Account. **(No discount available for credit card payments)**: *Please read and sign PART E below.*
Billing Frequency: ☐ Monthly ☐ Semi-Annual ☐ Annual

Option #3 ☐ Direct Billing **Billing Frequency:** ☐ Semi-Annual (2% discount) ☐ Annual (4% discount)

Part E • Payment Information and Authorization

PAYMENT INFORMATION for Pre-Authorized Debit (PAD) Payment Options

Name of Account Holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Branch Transit Number _____

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.

PAYMENT AUTHORIZATION for Pre-Authorized Debit (PAD) Payment Options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date 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 Payment 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. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

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 Manulife at 1-866-795-7285, or am_info@manulife.com or write to Manulife at P.O. 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.

Name of Account Holder _____ Signature of Account Holder _____

Second Signature If Joint Account _____ Dated _____ (DD/MM/YYYY)

Account Holder Address (if different from Applicant) _____

PAYMENT INFORMATION For Credit Card Payment Options

☐ Visa ☐ MasterCard ☐ American Express Account # _____ Expiry Date _____ (MM/YYYY)

PAYMENT AUTHORIZATION FOR CREDIT CARD PAYMENT 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 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.

Name of Cardholder _____ Signature of Cardholder _____

Second Signature If Joint Account _____ Dated _____ (DD/MM/YYYY)

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. **Additional medical information may be required to underwrite your application.**

Quebec residents only: You may detach the Medical Questionnaire and send it directly to Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

If you are detaching and mailing your Health and Dental Medical Questionnaire to Manulife separately, please complete the following:

Applicant's First Name _____ Initial ____ Last Name _____ Home Telephone _____

Section A • Individuals To Be Covered

Must be completed for all plans.

First name / Last name	Code	Sex	Birth date DD MM YYYY	Age	Smoker? No. of cigarettes daily	Height (cm/inch)	Weight (kg/lb)	Weight change in last year (kg/lb) Gain / Loss	Reason for weight change
	00								
Applicant	01								
Co-Applicant	02								
Dependent child	02								
Dependent child									

Section B • Treating Qualified Health Care Practitioner

Must be completed in full for Bronze Plan, Silver Plan and Gold Plan.

Name and telephone number 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")**:

	For Applicant	For Co-Applicant	For Dependant(s)
Name of Primary Health Care Provider			
Telephone number of Primary Health Care Provider			
Date of last consultation (DD/MM/YYYY)			
Reason for last consultation			
Tests, treatment, medication prescribed and diagnosis			
Results and current status			
Name and telephone number of **any other** Qualified Health Care Practitioner consulted or referred to			
Name of person who consulted other Practitioner and specialty			
Date of consultation (DD/MM/YYYY)			
Reason for consultation and results of consultation			

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

Section C • Simplified Questionnaire

Must be completed in full for Bronze Plan, Silver Plan and Gold Plan.

Have you, your co-applicant or any listed dependant(s):	Applicant	Co-Applicant	Dependant(s)
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	☐ Yes ☐ No	☐ Yes ☐ No
2. Consulted or been advised to consult a Qualified Health Care Practitioner about or had any known indication of a medical condition or complaint within the last year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No
4. a) Been advised to use a medication or treatment for a chronic and/or recurring medical condition?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Used any medication or treatment for 20 or more days within the past year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) OR do you, your co-applicant or any listed dependant(s) expect to use any medication or treatment within the next 3 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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. Ever 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 a cold or the flu.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered yes to any question, please complete Section D in full.

Section D • Medical Declaration

1. Have you, your co-applicant or any listed dependant(s) 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)

	Applicant	Co-Applicant	Dependant(s)
a) High blood pressure, high cholesterol, any circulatory or blood disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Heart or blood vessel disorder, heart murmur, chest pain, angina, stroke or transient ischemic attack (TIA)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Back, neck, disc, hip, knee or joint pain or disorder, fibromyalgia, osteoporosis, osteopenia, chronic pain, paralysis, weakness or numbness, or any other musculoskeletal pain or disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Digestive system disorder, Crohn's disease, ulcerative colitis, liver disease or disorder including hepatitis or hepatitis carrier state	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Mental, nervous, emotional or neurological disorder including depression, anxiety, attention deficit disorder or stress	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Alcohol or drug abuse, or any addiction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Allergies, asthma, bronchitis, respiratory disorder, shortness of breath or sleep apnea	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Immune disorder including testing for acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Arthritis, rheumatism or rheumatoid arthritis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Cancer, tumour, cyst, polyp or any growth	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Skin disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Breast disorder, menopause, reproductive disorder, infertility or assisted conception	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Bladder, kidney or prostate disorder or other genitourinary disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) Headaches or migraines	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) Diabetes, endocrine disorder, pituitary or thyroid disorder or lupus	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) Eye or ear disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) Any other complaint, condition, disease or disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please specify: _____

(Continue on next page)

Section D • Medical Declaration (continued)

	Applicant	Co-Applicant	Dependant(s)
2. Have you, your co-applicant or any listed dependant(s) ever been treated for, hospitalized for or had any known physical impairments, congenital abnormality, medical condition, injury, disease or disorder **not stated above?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you, your co-applicant or any listed dependant(s) ever been advised to have an investigation, hospitalization or surgery which **has not been completed**, or are awaiting any tests or test results?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you, your co-applicant or any listed dependant(s) ever been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered yes to questions 1 to 4 of Section D, please give explanation below:

Question No.	Name of Individual	Illness/Condition/Diagnosis	Date Diagnosed (DD/MM/YYYY)	Duration	Name and Telephone Number of Qualified Health Care Practitioner and/or Hospital Providing Treatment	Current Status of Condition

If more space is needed, please complete a separate sheet, signed and dated.

	Applicant	Co-Applicant	Dependant(s)
5. Are you, your co-applicant or any listed dependant(s) currently using or expecting to use in the next 3 months or have you discontinued use of in the last 3 months any drug, medication, serum or other treatment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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	Length of Time on This Drug/ Medication/Serum/Treatment	Date Discontinued (DD/MM/YYYY)

If more space is needed, please complete a separate sheet, signed and dated.

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

If yes: Name _____ Due Date _____ (DD/MM/YYYY)

Notice on Privacy and Confidentiality

The specific and detailed information requested on your application form is required to process your application. To protect the confidentiality of this information, Manulife will establish a financial services file from which this information will be used to process your application(s), offer and administer services, and process claims relative to the insurance applied for. Access to the file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services, and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign countries. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information your file contains and make corrections by writing to the Privacy Officer, Manulife, P.O. Box 1602, Stn 500-4-A, Waterloo, Ontario N2J 4C6.

Declaration and Authorization • All Applicants Must Complete This Section

☐ Check here if you do not wish to receive further information and material on Manulife 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 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 or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. 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 Notice on Privacy and Confidentiality. 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.

Signed at (City, Province)	Signature of Applicant	Dated (DD/MM/YYYY)
Signed at (City, Province)	Signature of Co-Applicant	Dated (DD/MM/YYYY)

Call **1-866-795-7285** if you require any assistance in completing this application.
Mail completed application to Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

Coverage underwritten by The Manufacturers Life Insurance Company (Manulife).

Accessible formats and communication supports are available upon request. Visit **manulife.com/accessibility** for more information.