Manulife Financial

Group Benefits
Evidence of Insurability for
Comprehensive Optional Critical Illness Insurance

INSTRUCTIONS - Please print all answers
If required, retain a photocopy for your files.

1a) Plan member information

Required if applying for member or spousal coverage

Plan contract number(s)	Division number	Plan member certificate number

Plan sponsor/employer name

Plan member name (last, first and middle initial)

Sex	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
◯ Male ◯ Female		( )	( )

Plan member's address (street number, street and apartment)

City	Province	Postal code

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

1 b) Basic medical information

Complete this section when you need to provide evidence of insurability as part of your application.

Height	Weight	Any weight change greater than 10 pounds in the last 12 months?
_____ m _____ cm _____ ft _____ in	◯ kg ◯ lb	◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb Reason: _____

Name of personal physician (last, first and middle initial)	Physician's phone number
	( )

Date of last visit (dd/mmm/yyyy)	Reason

Address of personal physician (street number, street and suite)

City	Province	Postal code

2 a) Spousal information

Only required if applying for spousal coverage

Spouse's name (last, first and middle initial)	Sex	Date of birth (dd/mmm/yyyy)
	◯ Male ◯ Female	

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

2 b) Basic medical information

Complete this section when you need to provide evidence of insurability for your spouse as part of the application.

Height	Weight	Any weight change greater than 10 pounds in the last 12 months?
_____ m _____ cm _____ ft _____ in	◯ kg ◯ lb	◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb Reason: _____

Name of personal physician (last, first and middle initial)	Physician's phone number
	( )

Date of last visit (dd/mmm/yyyy)	Reason

Address of personal physician (street number, street and suite)

City	Province	Postal code

3 Medical questionnaire

The following questions should be answered by each individual applying for coverage that needs to provide evidence of insurability as part of your application. Check your rate sheet for instructions. If more space is needed, use another form or sheet of paper (both must be signed and dated).

	Plan member	Spouse
A. **Have you ever had an application for any insurance that was declined, postponed or rated in any way?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Reason

B. **Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment, care or been advised to receive care or have further treatment for:**

	Plan member	Spouse
1) AIDS, a positive HIV test or AIDS-related disease?	◯ Yes ◯ No	◯ Yes ◯ No
2) Diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
3) Multiple sclerosis?	◯ Yes ◯ No	◯ Yes ◯ No
4) Organ transplant?	◯ Yes ◯ No	◯ Yes ◯ No
5) Hepatitis or hepatitis carrier state, other than Hep A?	◯ Yes ◯ No	◯ Yes ◯ No
6) Stroke or transient ischemic attack (TIA)?	◯ Yes ◯ No	◯ Yes ◯ No
7) Alzheimer's disease or Parkinson's disease?	◯ Yes ◯ No	◯ Yes ◯ No
8) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?	◯ Yes ◯ No	◯ Yes ◯ No
9) Motor neuron diseases, including but not limited to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)?	◯ Yes ◯ No	◯ Yes ◯ No
10) Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congestive heart failure, arrhythmia, peripheral vascular disease, or aneurysm?	◯ Yes ◯ No	◯ Yes ◯ No
11) Paralysis? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Is it trauma related? ◯ Yes ◯ No	◯ Local or ◯ General paralysis
Details		

	Plan member	Spouse
12) Chest pain? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause
Diagnosis		Status
Treatment		

	Plan member	Spouse
13) Congenital heart disorder? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause
Diagnosis		Status
Treatment		

	Plan member	Spouse
14) Heart murmur, shortness of breath, irregular heart beat, any disorder of the blood? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause
Diagnosis		Status
Treatment		

	Plan member	Spouse
15) Lymph, glandular disorder, or thyroid disorder? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)
Diagnosis	Status
Treatment	

3 Medical questionnaire (continued)

	Plan member	Spouse
16) Disorder of the eye or ear leading to blindness or deafness? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
17) Alcohol or drug abuse? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) and duration		
Treatment and results		
18) Disorder of the brain or nervous system, neurological disorder, epilepsy, optic neuritis, blurred or double vision, memory loss, weakness, tremor, numbness or tingling, impaired balance, loss of consciousness? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date of onset (dd/mmm/yyyy) / Date of last symptoms (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
Name and address of doctor seen		
19) Cancer, leukemia, Hodgkin's disease or other malignancy?	◯ Yes ◯ No	◯ Yes ◯ No
20) Growths, cysts or tumour? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
21) Dysplastic nevi or moles? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
22) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date of onset (dd/mmm/yyyy) / Date of last symptoms (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
Name and address of doctor seen		
C. 1) **Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, chronic kidney disease, angina, stroke, multiple sclerosis, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60?** If answered yes, please provide details in the chart below.	◯ Yes ◯ No	◯ Yes ◯ No

Member or spouse's family member	Name of family member	Relationship	Condition	Age at onset	Age at death (if applicable)
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					

3 Medical questionnaire (continued)

	Plan member	Spouse
2) If you have a family history of breast or ovarian cancer, have you had a breast exam, mammogram or other investigation? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Results		
3) If you have a family history of colon cancer, have you had a colonoscopy? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Results		
D. **During the last 5 years, have you had any abnormal result of any of the following: EKG, stress EKG, echocardiograms, mammogram, Pap smear (exclude if 2 subsequent Pap smears have been normal), PSA, sigmoidoscopy, colonoscopy, biopsy?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Test type / Date (dd/mmm/yyyy)		
Test results / Status		
Treatment		
E. **Other than for a common cold, osteoarthritis, bone fractures, have you had an abnormal result of any of the following: X-ray, CAT scan, or MRI?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Test type / Date (dd/mmm/yyyy)		
Test results / Status		
F. **Have you ever had elevated blood pressure or cholesterol?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Most recent results / Is it under control?		
Treatment		
G. **Are you aware of any symptoms or complaints for which you have not sought treatment or advice, or are you awaiting any tests or test results?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person		
Details		

4 Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan member's signature	Date signed (dd/mmm/yyyy)

Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

5 Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1