

# HEALTH & DENTAL PLAN APPLICATION

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

**\*All applicants must complete and sign Applicant's Declaration on back page.**

For Manulife Financial Use Only.

Keyed \_\_\_\_\_

Approval \_\_\_\_\_

WSF

Agent ID  
**ON2689**

Logo ID

## Part A • General Information

Applicant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Government Health Card Number \_\_\_\_\_

Apt. Number \_\_\_\_\_ Street Number and Name \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_

City or Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Occupation \_\_\_\_\_

**Applicant:** Office Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ E-mail \_\_\_\_\_  
**Co-Applicant:** Office Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ E-mail \_\_\_\_\_

If additional information is required during regular business hours, how may we contact you?  Home  Office  E-mail

Are you now covered or did you have previous group coverage with Manulife Financial 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)

Is this application intended to replace your current coverage?  Yes  No

Was your previous coverage Employer Group Coverage?  Yes  No

**Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):**

**Primary Applicant's Beneficiary** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to Primary Applicant \_\_\_\_\_  
**Co-Applicant's Beneficiary** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to Co-Applicant \_\_\_\_\_

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed, except in Quebec where benefits will be paid directly to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to Primary Applicant \_\_\_\_\_  
 Trustee: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to Co-Applicant \_\_\_\_\_

**For Quebec residents only:**

In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

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

## Part B • Plan Choice

I/We apply for the following Health Plan:

- Base Health and Dental Plan\*
- Bronze Health and Dental Plan
- Silver Health and Dental Plan
- Gold Health and Dental Plan
- Base Dental Plan\*
- Bronze Dental Plan\*
- Silver Dental Plan\*
- Gold Dental Plan\*

\* These plans do not require completion of the Medical Questionnaire of this application.

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

**\*All applicants must complete and sign Page 4, Applicant's Declaration**

## Part C • Billing Options

**Initial Payment:** I hereby authorize Manulife Financial to debit the initial 2 months premium, \$ \_\_\_\_\_, from my:

- Financial Institution Account     Credit Card Account

**Subsequent Payments:** Will be made by:

- Pre-Authorized Collection Plan (PAC) From My Financial Institution Account (Please also complete PART D below)

PAC Billing Frequency:  Monthly     Semi-annually (2% Discount)     Annually (4% Discount)

**Important: For verification purposes we require a VOID cheque if a payment is being withdrawn from your Financial Institution Account.**

- Credit Card (Please read and sign PART D below):  Visa     MasterCard     Amex    Account # \_\_\_\_\_    Expiry Date \_\_\_\_\_

(MM/YY)

Cardholder \_\_\_\_\_    Signature of Cardholder \_\_\_\_\_

(if other than Applicant or Co-Applicant)

Credit Card Billing Frequency:  Monthly     Semi-annually     Annually

**Please Note:** Billing frequency discounts are not available for Credit Card payment options.

- Direct Billing: Billing Frequency:     Semi-annually (2% Discount)     Annually (4% Discount)

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 NSF fee will be charged for all NSF transactions.

## Part D • Financial Institution

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. This authorization shall remain in effect unless prior written notice is given to Manulife Financial by the account holder requesting cancellation.

**For Pre-Authorized Collection 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.

\_\_\_\_\_  
Signature of account holder

\_\_\_\_\_  
Second signature if joint account



# 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 approval of this application.

**\*All applicants must complete and sign Applicant's Declaration below.**

## Section D • Medical Declaration

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

- 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: Check (✓) Yes or No to all questions.
 

|   |   |
|---|---|
| a) High Blood Pressure, Stroke, T.I.A. or Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No   | i) Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |
| b) Heart, High Cholesterol or Circulatory Disorder, Dizziness, Fainting or Blood Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No                                  | j) Cancer, Tumor or any Growth <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| c) Back, Joint or any Musculoskeletal Pain or Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No   | k) Skin Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| d) Digestive System Disorder, Liver Disease or Disorder including Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No  | l) Infertility/Reproductive Disorder/ Menopause <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| e) Nervous, Mental, Emotional or Stress Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No   | m) Bladder/Kidney Disorder or other Genitourinary Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f) Alcohol/Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No  | n) Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| g) Asthma/Allergies/Respiratory Disorder or Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No  | o) Diabetes/Endocrine Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) <input type="checkbox"/> Yes <input type="checkbox"/> No | p) Eye or Ear Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
|   | q) Other Condition/Disease/Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No                        |

Please specify: \_\_\_\_\_
- Have you, your Co-Applicant or any listed dependant(s) ever been treated or hospitalized for any Physical Impairment, Congenital Abnormality, Medical Condition, Disease or Disorder **not stated above?** Applicant  Yes  No Co-Applicant  Yes  No Dependand Child  Yes  No
- 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?** Applicant  Yes  No Co-Applicant  Yes  No Dependand Child  Yes  No
- If you answered "Yes" to question 1, 2 and/or 3, please provide explanation below:

| Question No. | Name of individual | Name of Illness/ Condition/Diagnosis | Date diagnosed | Duration | Name & Address of Qualified Health Care Practitioner and/or hospital providing treatment | Current status of condition |
|--------------|--------------------|--------------------------------------|----------------|----------|--|-----------------------------|
|              |                    |                                      |                |          |  |                             |
|              |                    |                                      |                |          |  |                             |
|              |                    |                                      |                |          |  |                             |

- Are you, your Co-Applicant or any listed dependant(s) currently using or expect to use in the next 3 months any drug, medication, serum or other treatment?  Yes  No  Yes or No If yes, provide details below:

| Name of individual | Name of the drug/ medication/serum/treatment | Condition being treated | Strength & daily dosage of the Drug/Medication/serum | Monthly cost | Length of time on this drug/medication/serum/treatment |
|--------------------|--|-------------------------|--|--------------|--|
|                    |  |                         |  |              |  |
|                    |  |                         |  |              |  |
|                    |  |                         |  |              |  |

- Are you, your Co-Applicant or any listed dependant(s) pregnant?  Yes  No

If yes, Name \_\_\_\_\_ Due Date \_\_\_\_\_ (DD/MM/YYYY)

## 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<br>✕ |
|---|--------------|----------------|

## 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 or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. 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 Manulife Financial's 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 \_\_\_\_\_ Signature of Applicant \_\_\_\_\_ Signature of Co-Applicant \_\_\_\_\_ Dated \_\_\_\_\_ (DD/MM/YYYY)

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

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