Manulife

Application for reinstatement of life insurance
for policies that have lapsed within the past 6 months

Mail or fax completed form to Manulife, Individual Insurance at:

In all provinces except Quebec
500 King Street North
PO BOX 1669
WATERLOO ON N2J 4Z6
Fax: 1-877-763-8834

In Quebec
2000 RUE MANSFIELD
BUREAU 1310
MONTREAL QC H3A 3A1
Fax: 1-877-271-5494

- *You* and *your* mean the policy owner unless otherwise identified. *We*, *us* and *our* mean the insurer of the policy identified in section 1.
- Use this form to reinstate a life insurance policy that lapsed within the past six months. Use *Application for change*, NN7001E, to reinstate a policy that lapsed more than six months ago.
- We may require further evidence of insurability to reinstate your policy.

1 Information about the policy

Name of policy owner (first, middle initial, last)			Policy number
Name of advisor (first, middle initial, last)		Advisor code	Branch code
Name of insured person "A" (first, middle initial, last)	Date of birth (dd/mmm/yyyy – for example, 23/JUL/1948)		
Address	City	Province	Postal code
Name of insured person "B" (first, middle initial, last)	Date of birth (dd/mmm/yyyy – for example, 23/JUL/1948)		
Address	City	Province	Postal code

2 Evidence of insurability

In this section, *you* means any person insured under this policy including any person insured under a child protection rider or other rider.	**Person "A" to be insured**	**Person "B" to be insured**	**Children under a child rider**
1. Within the past year, have you been admitted or been advised to be admitted to a hospital or medical facility, or had surgery performed or recommended?	☐ No ☐ Yes	No Yes	☐ No ☐ Yes
2. Within the past year, have you been treated for heart disease, diabetes, stroke or cancer, or has treatment for these conditions been recommended by a health care professional?	☐ No ☐ Yes	No Yes	☐ No ☐ Yes
3. Within the past year, have you been absent from work for more than 10 consecutive days for any accident or sickness?	☐ No ☐ Yes	No Yes	☐ No ☐ Yes
4. Have you ever been diagnosed with any immune deficiency disorder, including AIDS, AIDS Related Complex (ARC) or any generalized enlargement of the lymph glands or have you had any test results that indicate possible exposure to the AIDS (i.e. HIV, HTLV-III, LAV) virus?	☐ No ☐ Yes	No Yes	☐ No ☐ Yes
5. Have you ever been declined for life, disability, critical illness or long-term care insurance, or been offered restricted coverage or coverage at a non-standard rate?	☐ No ☐ Yes	No Yes	☐ No ☐ Yes

Details

If you answered *yes* to any of the questions in section 2, list the question number and provide full details here, including dates (and the name and address of any doctor you consulted, if applicable). If you need additional space, you can attach a separate sheet of paper that has been signed, dated and witnessed.

3 Authorizations, agreements and signatures

In this section *you* and *your* mean the policy owner and the insured person. By signing below, you consent that we may use the personal information that we collect in this application to evaluate your application and properly administer any financial services and products we provide.

Please read this entire section carefully. It explains how your personal information is used to issue and administer the insurance policy you have applied for.

At the end of the section we ask you to sign. Your signature means that you authorize and agree to the ways we collect, use, share and retain your personal information and that you agree to the terms described in this form. You may not alter any of the wording in section 3. Any attempt to do so will be of no effect.

Collecting your personal information

In addition to the personal information you provide in this form, we may need to:

- request any test that may be necessary for us to decide if and on what terms to insure you, such as a medical examination, X-ray or blood test
- obtain from any doctor, medical practitioner, hospital, medically related facility, insurance company or other organization or person that has any information or records of you, your financial situation or your health, any information that we and applicable reinsurers require to issue or administer the insurance policy you have applied for
- obtain your personal information from the Medical Information Bureau, as explained in the notice that we have provided to you
- obtain a copy of all driving-related information from the Motor Vehicle Division in any province that is relevant to this change request or reinstatement
- obtain a personal investigation, credit bureau report and/or a consumer report.

We may appoint an agent to collect your personal information on our behalf.

Sharing your personal information

We may share your personal information with the following people, organizations or service providers:

- our employees and agents who require this information to perform their jobs
- third-party service providers who require this information to provide their services to us, which may include:
  - paramedical agencies
  - underwriters
  - claims investigators and investigative agencies
  - providers of information processing and storage, programming, printing, mailing and distribution services
- applicable reinsurance companies to allow them to evaluate and administer any insurance risk that they accept
- your advisor and any agency that employs your advisor or has named your advisor as its agent, and their employees
- the Medical Information Bureau, as explained in the notice that we have provided to you
- people to whom you have granted access
- people who are legally authorized to view your personal information.

These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. Your information may be shared as required by the laws of those jurisdictions.

There are other situations where we may share aspects of your personal information with others, as described below.

- We may share medical information collected about you with your doctor.
- We may share your personal information with an organization or person from whom we are collecting information about you, but only as required to obtain the information we need.
- If laboratory tests performed on our behalf show that you have tested positive for infectious diseases such as HIV or hepatitis, we may report this information to the appropriate public health authorities, as required.

Because the medical information you include on this form becomes part of the printed contract, in the case of a corporate or joint policy, your medical information may be included in the policy contract issued to the policy owner(s) and any subsequent owners.

3 Authorizations, agreements and signatures (continued)

Additional privacy policy information

Your personal information will be stored and may be accessed as described in Manulife's Canadian Division privacy policy. (This document is available from our Privacy Office or on our website at www.manulife.ca >PRIVACY POLICY.) You can contact our Privacy Office by writing us at:

Privacy Office – Individual Insurance
25 Water Street S.
PO Box 800 Stn C
Kitchener ON N2G 4Y5

Terms for reinstating policies

If we agree to reinstate your policy, this form becomes part of that document.

This reinstatement form includes the pages numbered 1 to 5, any answers you have provided, plus all written statements submitted in connection with it.

By signing on the next page, you agree that:

- You ask us to reinstate the policy identified on page 1 of this form.
- A policy reinstatement will become effective when any payment due to us as a result of the reinstatement has been paid and the application for reinstatement has been approved by us at our head office provided there has been no change in the insurability of the insured person since this form was completed.
- We have the right to question the validity of the reinstatement if an insured person or a policy owner misrepresented a material fact (whether fraudulently or not) by not disclosing it or stating it incorrectly in any application or in any medical examination or in any information we have used as evidence of insurability.
- The contestability period for any insurance coverage is the first two years from these dates:
  - the effective date you made a change that required updated evidence of insurability for that coverage
  - the date your policy was last reinstated
  - the coverage issue date.
- If the age or sex of any insured person has been misstated, any benefit payable on any insurance or rider coverage for that insured person will be increased or decreased to the amount we would have paid based on the last premium paid for that coverage, and the amount of insurance the last premium would have purchased according to the insured person('s) correct age or sex. If we would not have issued the coverage, we have the right to declare the coverage invalid within the period permitted by law.
- We can contest with respect to fraud at any time.
- You understand that the authorizations you provide will remain in effect after the policy owner and the people to be insured die so that we can evaluate and review any claim under the policy and fulfill our legal requirements.
- If the premiums or payments for this policy are paid by automatic monthly withdrawal, and the policy lapsed within the past three months, we will resume the automatic monthly withdrawal plan and the owner(s) of the bank account from which withdrawals will be made:
  - agree that we can increase the monthly withdrawal by the new amount required to keep the policy in effect as a result of this reinstatement
  - **waive the right to receive 10 days' notice of the amount of automatic monthly withdrawal.**

  If the premiums for this policy are paid by automatic monthly withdrawal, and the policy lapsed more than three months ago, the payor must complete the attached *Request to change or create a new automatic monthly withdrawal plan,* NN0312E to confirm the automatic withdrawal plan details for the reinstated policy.

3 Authorizations, agreements and signatures (continued)

Your advisor's access to your personal information

- If our findings concerning your blood pressure, cholesterol level or physical build affect your policy change or reinstatement, we may share this information with your advisor.
- If the information you provide in the application or in any telephone interview or paramedical interview affects your policy change or reinstatement, we may tell your advisor whether the relevant information relates to your family history, medical information or lifestyle.

You agree that we may share the information with your advisor as described above and that your advisor can use this information to discuss your insurance options with you. If you do not agree, select the applicable box below.

Insured person "A" does not agree ☐

Insured person "B" does not agree ☐

Signatures

Please review this form, including the authorizations and agreements, and sign below.

By signing below you are confirming that:

- you understand that approval of the reinstatement is subject to contract provisions and our current administrative rules.
- you have read this form and confirm that the statements in it are complete, current and accurate. You will immediately notify us of any errors or omissions.
- you agree to the terms described in this form.
- a copy of this document is as valid as the original.

Signed at (city or town, province)	Date (dd/mmm/yyyy – for example, 23/JUL/2013)	
Signature of insured person "A" ✘	Signature of witness ✘	Date (dd/mmm/yyyy)
Signature of insured person "B" ✘	Signature of witness ✘	Date (dd/mmm/yyyy)
Signature of policy owner (if not insured person "A" or "B")* ✘ Title (if applicable):	Signature of witness ✘	Date (dd/mmm/yyyy)
Signature of policy owner (if not insured person "A" or "B")* ✘ Title (if applicable):	Signature of witness ✘	Date (dd/mmm/yyyy)

Initial here | Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.

* **If the owner is a corporation, we require:**
- two signing officers' signatures and titles
  or
- one signing officer's signature, title and the corporate seal; if the corporation does not have a seal and you are the only person authorized to sign on behalf of the corporation, in addition to signing, write your initials in the box provided.

Authorizations for automatic monthly withdrawals (for account owners that are not insured people or policy owners)

Name of account owner #1 (first, middle initial, last) (if that person has not signed above)	Name of account owner #2 (first, middle initial, last) (if that person has not signed above)
Signature of account owner #1* ✘ Title (if applicable):	Signature of account owner #2* ✘ Title (if applicable):
For corporations: Full legal name (including Company, Limited, Inc., etc.)	

Initial here | Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.

Check form for errors

Authorization to share information – Person A

You and *your* refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. *Us* and *our* refer to The Manufacturers Life Insurance Company (Manulife). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, or of your children or their health (if applicable), to share or exchange information with us or applicable reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal health information to the Medical Information Bureau.

Signed at (city or town)	Date (dd/mmm/yyyy)
Signature of person "A" to be insured ✘	
Signature of witness ✘	

If the person to be insured is under age 18:
Relationship to the person to be insured:
☐ mother ☐ father ☐ guardian (tutor, in Quebec)

Signature of parent or guardian/tutor ✘
Signature of witness ✘

Authorization to share information – Person B

You and *your* refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. *Us* and *our* refer to The Manufacturers Life Insurance Company (Manulife). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, or of your children or their health (if applicable), to share or exchange information with us or applicable reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal health information to the Medical Information Bureau.

Signed at (city or town)	Date (dd/mmm/yyyy)
Signature of person "B" to be insured ✘	
Signature of witness ✘	

If the person to be insured is under age 18:
Relationship to the person to be insured:
☐ mother ☐ father ☐ guardian (tutor, in Quebec)

Signature of parent or guardian/tutor ✘
Signature of witness ✘

Manulife

Receipt for payment

Amount received $

The premium must be paid by cheque in Canadian funds drawn on a Canadian financial institution, and made payable to Manulife Financial.

By signing below, the advisor confirms that this premium is for any life insurance applied for in this form, covering the people listed below.

Name of person "A" to be insured (first, middle initial, last) ✘		Name of person "B" to be insured (first, middle initial, last) ✘
Total amount of insurance coverage applied for $	Date (dd/mmm/yyyy)	Signature of advisor ✘

Detach and leave with policy owner

Manulife

Medical Information Bureau

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to the Medical Information Bureau based on your application, or to other insurance companies to which you apply for life, critical illness insurance, disability or long term care insurance or to which a claim for benefits has been made.

The Medical Information Bureau is a non-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, the Medical Information Bureau will share any information it has on file.

You may review the information in your file, and request a correction if necessary, by contacting the bureau at:

Medical Information Bureau
330 University Avenue, Suite 501,
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com