Manulife

Applic

when evid

For a Manulife Quick Issu
For a long term care polic
Use this form to make a c bined insurance solution.
In this application, *we*, *us* e policy owner or the people
to be insured. At the star
For Synergy, the word *po*

Section 1 – Information about the change

In this section, *you* and *your* refer to the policy owner.

1.1 Tell us the policy number and the name of the owner of the policy you want to change.

Policy number	Name of policy owner (first, middle initial, last) or full legal name of corporation

1.2 Changes to any type of policy (Select all that apply.)

Change requested	Information required
☐ **Change status from smoker to non-smoker (for a policy or rider issued without Healthstyle categories)**	**For a l or c cal ill s polic a S ergy olutio Comple se ons: 1 3, 5.1- , 6, 8, and th dvisor's report** **For a dis y policy. Complete tions: 1, 2 –5.5, 7, 11, e Advisor's report**
☐ **Change Healthstyle category (for a policy or rider issued with Healthstyle categories)**	**from Healthstyle** ☐ **to Healthstyle** ☐ **Healthstyle 1** means no use of tobacco or nicotine products for more than 15 years, excellent health and a low-risk lifestyle. **Healthstyle 2** means no use of tobacco or nicotine products for more than two years, very good health and a low-risk lifestyle. **Healthstyle 3** means no use of tobacco or nicotine products for more than one year, good health and standard lifestyle. **Healthstyle 4** means use of tobacco or nicotine products other than cigarettes and/or marijuana. **Healthstyle 5** means use of cigarettes and/or marijuana. **Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor's report**
☐ **Reinstate policy** **OR**	Date of lapse: Amount of payment made for any outstanding premium (including any outstanding loans and interest): $
☐ **Reinstate automatic coverage enhancement (for a disability policy)**	**For a life or critical illness policy, or a Synergy solution:** **Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report** **For a disability policy:** **Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report** **Send us:** ☐ outstanding premium payment/deposit ☐ *Identifying owners of Individual Insurance policies*, NN1558E (For universal life and whole life policies only)
☐ **Improve insurance rating** **OR** ☐ **Reconsider exclusion**	**For a life or critical illness policy, or a Synergy solution:** **Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor's report** **For a disability policy:** **Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report**

Section 1 – Information about the change (continued)

1.3 Changes to a disability policy (Select all that apply.)

▶▶ **Do not complete for any changes to a Synergy solution.**

Change requested	Information required
☐ **Change occupation class**	**from** ____ **to** ____ **Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report**
☐ **Increase monthly benefit (for a Proguard or Venture policy issued after November 23, 2013)** For a Proguard or Venture policy issued before November 23, 2013, or for other disability products, use *Application for life, disability and critical illness insurance*, NN7000E.	**from** $ ____ **to** $ ____ **Complete sections: 1, 2, 3.1, 5.1-5.5, 6, 7, 11, 12 and the Advisor's report** **Send us:** ☐ premium payment
☐ **Decrease elimination period**	**from** ____ **to** ____ **Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report**
☐ **Remove Income Loss Replacement Plan (ILRP) (for a disability policy issued in the past 5 years if the amount of insurance is not changing)**	**Complete sections: 1, 2, 3.1, 11.1–11.3, 12 and the Advisor's report**
☐ **Increase benefit period**	**from** ____ **to** ____ **Com te secti : 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 an e Advisor's report**
☐ **Convert disability insurance**	**Select e.** ☐ **conv -Sell P to Ventu** ☐ **conve penseCo eGua to OR ☐ Venture** ☐ **convert IncomePlus to ☐ Proguard OR ☐ Venture** **Complete sections: 1, 2, 3.1, 11.1–11.3, 12 and the Advisor's report** **Send us:** ☐ premium payment ☐ original policy

Void

1.4 Changes to a life or critical illness policy, or a Synergy solution (Select all that apply.)

Change requested	Information required
☐ **Add or increase a child rider** To add a new child protection rider on a life insurance policy or a new child protection rider–life on a Synergy solution, use *Application for a child protection rider*, NN1643E.	☐ **Add a new children's Lifecheque rider on a Lifecheque policy or a new child protection rider–critical illness on a Synergy solution.** Amount of insurance $ ____ ☐ **Increase an existing children's Lifecheque rider or child protection rider–critical illness** **from** $ ____ **to** $ ____ **Complete sections: 1, 2, 3.3, 7.5, 7.6, 8, 12 and the Advisor's report**
☐ **Add rider or benefit for a person insured on the policy**	Name of rider or benefit ____ Amount of addition $ ____ **Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report** **Send us:** ☐ financial statements for the business the coverage applies to for the last three consecutive fiscal years (if adding a BVP rider) ☐ documentation showing the current equity position of each insured person in this business (if adding a BVP rider)

Section 1 – Information about the change (continued)

Change requested	Information required
☐ **Add a coverage** **OR** ☐ **Add a new insured person**	Coverage amount $ | Coverage type | Coverage option/COI **For a Performax Gold policy, you must also tell us:** **1. Which performance credit option you would like?** ☐ **accumulation account** ☐ **paid-up insurance** ☐ **term option** Term option amount $ **2. Do you want to add deposit option insurance to this coverage?** ☐ **No** ☐ **Yes** **If *yes*, tell us:** **a. Planned first coverage year deposit option payment** $ ☐ for ____ years OR ☐ planned lifetime deposit option payments $ **b. Additional amount you want to be billed** $ **c. Additional amount you want added to your existing automatic monthly withdrawal** $ **d. Allocation instructions for additional payments** **These instructions apply to (select one or both):** ☐ this additional payment of $ ☐ all future additional payments Tell us how you want to allocate your additional payment. | % of additional payment allocated To deposit option insurance coverage number — % To deposit option insurance coverage number — % To deposit option insurance coverage number — % To accumulation account — % **Total** **100%** **Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report**
☐ **Increase amount of insurance** **OR** ☐ **Increase Term Option amount (before the first policy anniversary of a Performax Gold policy only)** If the Term Option amount is increased, the Term Option Guarantee may be reduced or cancelled. See the *Performax Gold Product Guide* for details.	**from** $ **to** $ **For:** **Family Term, Business Term, Limited Pay UL, Security UL, Security Universal Life or InnoVision, OR** **a term insurance rider on Performax Gold, Manulife UL or Synergy, you must choose one option below:** ☐ replace existing coverage with current-dated coverage for the higher amount **OR** ☐ add a new layer of coverage for the amount of the increase only **Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report**
☐ **Change death benefit type (If net amount at risk increases)** If net amount at risk does not increase, use *Request for change*, NN0739E.	**to** **Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report**
☐ **Switch cost type and/or duration** For a Synergy solution, a change in cost type applies to all policies.	☐ **for all coverages** **OR** ☐ **for** Coverage number **OR** ☐ **for Synergy** **from** **to** **Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report**
☐ **Decrease waiting period to 90 days (for the disability insurance policy in a Synergy solution)**	**Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report**

Section 1 – Information about the change (continued)

Change requested	Information required
☐ **Plan change or plan exchange** If no evidence of insurability is required, use *Plan exchange or plan change application*, NN1556E.	**from** ____ **to** ____ **Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report** **Send us:** ☐ product page for new plan (for universal life, whole life, Family Term Life, Business Term Life or Lifecheque only) ☐ signed illustration for new plan (for universal life or whole life only)
☐ **Change performance credit option (for a Performax Gold policy)** Use *Request for change*, NN0739E if you are changing: • from term option to paid-up insurance • from term option to accumulation account or • from paid up insurance to accumulation account.	**for** Coverage number ____ **Select one.** ☐ **from accumulation account to paid-up insurance** ☐ **from accumulation account to term option** Term option amount $ ____ ☐ **from paid-up insurance to term option** Term option amount $ ____ **Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report**
☐ **Change dividend option (If net amount at risk increases)** If net amount at risk does not increase, complete *Request for change*, NN0739E.	**from** ____ **to** ☐ **paid-up insurance** **OR** ☐ **term option** **Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor's report**
☐ **Change dividend option for Manulife Par** Use Request for change, NN0739E if you are changing from paid-up insurance to cash.	**from** h to p -up insu **Compl se ns: , 3, 5.1 7, 6 8, and t dvisor's report**
☐ **Apply for select rates (for a Commercial Union policy)**	**Complete sections: 1, 2, –5.7, 6, 7, 8, 12 the Advisor's report**
☐ **Deposit option change requiring underwriting** For Performax Gold, use *Deposit Option*, NN0713E if you are: • increasing the annual or lifetime limits for your deposit option, or • adding a deposit option to an existing coverage. For Manulife Par, use *Increase lifetime deposit option limit*, NN1678 if you are: • increasing the lifetime deposit option limit on a Manulife Par policy.	

Section 1 – Information about the change (continued)

Change requested	Information required
☐ **Exercise GIO or BVP option** If no evidence of insurability is required, use *Term conversion application or exercising a GIO or BVP*, NN0431E.	☐ business value protector option **OR** ☐ guaranteed insurability option ☐ age ☐ policy anniversary ☐ alternative Option date (dd/mmm/yyyy) | Event establishing alternative option (Example: birth of child) What proof of the event is being submitted? (Example: birth certificate) **Complete sections: 1, 2, 3, 4, 9, 12 and the Advisor's report** **Send us:** ☐ signed product page ☐ signed illustration ☐ premium payment/deposit ☐ void cheque and/or automatic monthly withdrawal details (if applicable) ☐ financial statements for the business the coverage applies to for the last three consecutive fiscal years (if exercising BVP) ☐ documentation showing the current equity position of each insured person in this business (if exercising BVP)
☐ **Exercise option to purchase permanent life insurance at expiry (for a Synergy solution)** If no evidence of insurability is required, use *Request for change*, NN0739E.	**Complete sections: 1, 2, 3, 4, 9, 12 and the Advisor's report** **Send us:** ☐ signed product page ☐ signed illustration (if required) ☐ premium payment/deposit ☐ void cheque and/or automatic monthly withdrawal details (if applicable)
☐ **Convert term insurance** If you are not making any other changes to your policy or if no evidence of insurability is required, use *Term conversion application or exercising a GIO or BVP*, NN0431E. **Note:** There may be a taxable gain if the term policy you are converting has cash value at the time of conversion.	**a. How do you want the insurance to be issued?** ☐ issue the new insurance on a new policy ☐ issue the policy in English OR ☐ émettre le contrat en français **OR** ☐ issue the new insurance as a new coverage on the existing policy | Policy number **b. If there is a disability waiver rider on the policy you want to convert, are any people insured by that rider currently totally disabled and unable to perform the duties of their regular occupation?** ☐ No ☐ Yes **c. Converting an individual policy or rider** (If you want to terminate any insurance other than term, complete *Policy surrender*, NN0387E.) **The insurance being converted is contained in the:** ☐ term insurance rider ☐ spouse protection rider ☐ child rider | Child's date of birth ☐ survivor's benefit ☐ term option (multiplier dividend option) ☐ other **d. Tell us the following information about the insurance you are converting:**

Name of insured person (first, middle initial, last)	Coverage date (dd/mmm/yyyy)	Current term coverage amount
		$
Amount of current term coverage to be converted	**Amount of current term coverage to be cancelled**	**Amount of current term coverage to remain in the original policy or in a new term rider**
$	$	$

e. Which of the following riders or benefits do you want to transfer to the new policy?

Rider or benefit	Amount of coverage to transfer to new policy	Rider or benefit	Amount of coverage to transfer to new policy
☐ accidental death benefit	$	☐ child rider child's date of birth:	$
☐ disability waiver rider	**N/A**	☐ child rider child's date of birth:	$

Section 1 – Information about the change (continued)

Change requested	Information required
	f. For a child rider with a critical illness insurability benefit If you are applying to convert a child rider with a critical illness insurability benefit, the insured person must answer the following questions: **1. Do you have or have you applied for critical illness insurance that provides a total of $1,800,000 or more coverage with The Manufacturers Life Insurance Company and other insurance companies?** ☐ No ☐ Yes **2. Have you ever been diagnosed with cancer of any kind, heart attack, coronary artery disease requiring surgery or any condition requiring coronary angioplasty, stroke, multiple sclerosis, aplastic anemia, bacterial meningitis, blindness, deafness, loss of speech, kidney failure, paralysis, loss of limbs, coma, Alzheimer's disease, motor neuron disease, HIV, Parkinson's disease, severe burns, benign brain tumour or have you been placed on the waiting list for or undergone a major organ transplantation, or undergone aortic surgery or heart valve replacement, or do you require assistance to perform any of the routine activities of daily living, including bathing, dressing, eating, toileting, transferring and maintaining continence?** ☐ No ☐ Yes If you answered ***yes*** to question 1 or 2, we regret that we cannot offer you critical illness insurance without additional evidence of your insurability. If you want to apply for critical illness insurance by providing evidence of insurability, complete and submit the *Application for life, disability, and critical illness insurance*, NN7000E. If you answered ***no*** to questions 1 and 2, tell us the amount of insurance you want to purchase. You may buy a combination of life insurance and critical illness insurance as long as the total amount of insurance is not more than $250,000 and the critical illness portion of the total insurance is not more than $100,000. Amount of life insurance $ | Amount of critical illness insurance $ **Complete sections: 1, 2, 3, 4, 9, 12 and the Advisor's report** **Send:** ☐ si d product page (for universal life, whole , Family Term or Business Term only) ☐ ed illus univ life c only) ☐ mium ment/d sit ☐ oid che and/or oma mo withd al details (if applicable)
☐ **Other**	Provide details about the change you want to make

Before you buy

If you want more information about the insurance product you are considering, visit our client website at www.manulife.ca/b4ubuy

Where to send the completed form

Send this completed application and any additional documents required to:

Manulife
500 King Street North
PO BOX 1669
WATERLOO ON N2J 4Z6

Manuvie
2000 rue Mansfield, bureau 1310
MONTREAL QC H3A 3A1

To help you use this form

If your client is applying for a child rider or adding a child to an existing rider, provide all requested information about the children to be insured where you see this icon. It helps you locate the information we need for a child rider.

If a child is to be one of the people insured on this policy, provide the information for that child in the "Person A" or "Person B" boxes. Do not provide information in sections 3.3 and 7.5.

Section 2 – General information

In this section, *you* and *your* refer to the policy owner.

2.1 Direct deposit for refunds

If your policy change produces a refund, deposit it

☐ the bank account from which we are taking your automatic monthly withdrawal for policy number

Policy number

OR

☐ the bank account identified in section 9.6 (for term conversions)

2.2 Special instructions

Section 3 – Information about the people to be insured

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. The questions must be answered by the people to be insured. If a person to be insured is a minor, the minor's parent or guardian (tutor, in Quebec) must provide the information on their behalf. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider.

3.1 Person "A" to be insured

a.

Legal name (first, middle initial, last)				
Previous name (if you have used a different name in the last two years)			Date of birth (dd/mmm/yyyy)	Sex ☐ male ☐ female
Address (number and street)	Unit	City or town	Province	Postal code
Number of years at this address	Preferred contact number ( )	Place of birth (province and country)		

b. Are you a Canadian citizen or do you have permanent resident status?

☐ Yes ☐ No If *no*, provide details.

Previous country of residence	Your current immigration status in Canada	When did this status come into effect? (dd/mmm/yyyy)

3.2 Person "B" to be insured

a.

Legal name (first, middle initial, last)				
Previous name (if you have used a different name in the last two years)			Date of birth (dd/mmm/yyyy)	Sex ☐ male ☐ female
Address (number and street)	Unit	City or town	Province	Postal code
Number of years at this address	Preferred contact number ( )	Place of birth (province and country)		

b. Are you a Canadian citizen or do you ha perma t resident status?

☐ Yes ☐ No If *no*, provide details.

Previous country of residence	our cu immigra stat Ca a	Wh id this status come into effect? (dd/mmm/yyyy)

3.3 Children to be insured under a child rider

▶▶ Complete this section only if you are applying for a child rider. Otherwise go to section 4.

In this section, *you* and *your* refer to the policy owner and the people to be insured. Evidence of insurability may be required for each child and the person or people insured under the policy.

a. Tell us the following information for *each* child to be insured under this rider.

	Name (first, middle initial, last)	Relationship to person to be insured	Sex	Date of birth
Child 1		☐ child ☐ stepchild ☐ legally adopted child	☐ male ☐ female	(dd/mmm/yyyy)
Child 2		☐ child ☐ stepchild ☐ legally adopted child	☐ male ☐ female	(dd/mmm/yyyy)
Child 3		☐ child ☐ stepchild ☐ legally adopted child	☐ male ☐ female	(dd/mmm/yyyy)
Child 4		☐ child ☐ stepchild ☐ legally adopted child	☐ male ☐ female	(dd/mmm/yyyy)

b. Do all the children to be insured under this rider live with you or the policy owner? ☐ Yes ☐ No

If *no,* who do the children live with?

Child 1	Name of caregiver (first, middle initial, last)	Relationship to child

When did this child last visit either the people to be insured or the policy owner? Date (dd/mmm/yyyy)

How often does this child visit either the people to be insured or the policy owner?

Child 2	Name of caregiver (first, middle initial, last)	Relationship to child

When did this child last visit either the people to be insured or the policy owner? Date (dd/mmm/yyyy)

How often does this child visit either the people to be insured or the policy owner?

Child 3	Name of caregiver (first, middle initial, last)	Relationship to child
When did this child last visit either the people to be insured or the policy owner?	Date (dd/mmm/yyyy)	How often does this child visit either the people to be insured or the policy owner?

Child 4	Name of caregiver (first, middle initial, last)	Relationship to child
When did this child last visit either the people to be insured or the policy owner?	Date (dd/mmm/yyyy)	How often does this child visit either the people to be insured or the policy owner?

Section 4 – Beneficiary information for life insurance

In this section, *you* and *your* refer to the policy owner.

We will change your beneficiary and trustee appointment only if we approve this application for change. If this application for change is declined, your current beneficiary and trustee appointment will not change.

▶▶ **Complete this section for life insurance only (including life insurance under Synergy).** For living benefits insurance, a different form is required to designate beneficiaries or direct payment. See the list below.

Choosing a beneficiary for life insurance

You may choose one or more beneficiaries for each insured person. The beneficiary receives the benefit if they are alive and eligible as described below, when the death of the insured person results in the payment of a death benefit. If you want to choose a different beneficiary for a rider or specific coverage, complete and submit *Beneficiary designation and coverage level*, NN0772E, or for Synergy, *Beneficiary designation and direction to pay for Synergy*, NN1609E.

We will divide the death benefit evenly among the surviving eligible beneficiaries, unless you tell us the percentage of the death benefit each beneficiary is to receive.

You may choose both beneficiaries and secondary beneficiaries. A secondary beneficiary will only receive a death benefit if no beneficiaries are eligible to receive the benefit. A beneficiary is not eligible to receive a benefit if they die before the benefit is payable or they are otherwise disqualified.

About irrevocable beneficiary designations

If you name an irrevocable beneficiary, you will need that beneficiary's written consent to make changes to the policy, assign benefits or cash value, withdraw funds or transfer ownership. A minor can't give consent until reaching the age of majority. Parents or guardians (tutors, in Quebec) can't give consent on behalf of a minor beneficiary.

In all provinces except Quebec, beneficiary designations are **revocable**, unless you select *irrevocable*.

In Quebec, if you name your married or civil union spouse as a beneficiary, the designation is **irrevocable**, unless you select *revocable*. All other beneficiary designations are **revocable**, unless you select *irrevocable*.

Related forms for living benefits insurance (including critical illness and disability insurance under Synergy)

To direct payments in New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, Prince Edward Island, Saskatchewan, and Yukon, use:

- For Lifecheque, *Direction to pay for Lifecheque policies*, NN0999E
- For Synergy, *Beneficiary designation and direction to pay for Synergy*, NN1609E
- For disability (except Synergy), *Direction to pay for disability policies and critical illness policies (except Lifecheque and Synergy)*, NN1611E

To designate beneficiaries in Alberta, British Columbia, Manitoba, Ontario, and Quebec, use:

- For Lifecheque, *Beneficiary designations for Lifecheque policies*, NN1467E
- For Synergy, *Beneficiary designation and direction to pay for Synergy*, NN1609E
- For disability (except Synergy), *Beneficiary designations for disability policies or critical illness policies (except Lifecheque and Synergy)*, NN1584E

Section 4 – Beneficiary information for life insurance (continued)

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

4.1 Beneficiaries – Person "A" to be insured

a. Beneficiaries

Name of beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %

Total 100%

b. Secondary beneficiaries (called subrogated beneficiaries in Quebec)

Name of secondary or subrogated beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of secondary or subrogated beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of secondary or subrogated beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %

Total 100%

4.2 Beneficiaries – Person "B" to be insured

a. Beneficiaries

Name of beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %

Total 100%

b. Secondary beneficiaries (called subrogated beneficiaries in Quebec)

Name of secondary or subrogated beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of secondary or subrogated beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %
Name of secondary or subrogated beneficiary (first, middle initial, last)	Relationship*	☐ revocable ☐ irrevocable	Share %

* **In Quebec**, tell us the beneficiary's relationship to the owner.
In all provinces except Quebec, tell us the beneficiary's relationship to the person to be insured.

Total 100%

4.3 Trustee for minor beneficiaries (not applicable in Quebec)

Complete this section if a beneficiary you've named above is a minor. By completing this section, you agree that any benefit that becomes payable to a minor beneficiary will be paid to the trustee to hold in trust for the child until the child comes of legal age.

Name of minor beneficiary (first, middle initial, last)	Name of trustee (first, middle initial, last)	Relationship of trustee to beneficiary
Name of minor beneficiary (first, middle initial, last)	Name of trustee (first, middle initial, last)	Relationship of trustee to beneficiary
Name of minor beneficiary (first, middle initial, last)	Name of trustee (first, middle initial, last)	Relationship of trustee to beneficiary

Section 5 – Personal information

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider. All people to be insured must complete this section.

5.1 Residency and travel

a. Do you expect to change your country of residence?

Person "A" to be insured

☐ No ☐ Yes If *yes*, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing tell us what your new occupation will be.

Details

Person "B" to be insured

☐ No ☐ Yes If *yes*, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing tell us what your new occupation will be.

Details

b. Do you expect to travel outside Canada and the United States within the next 12 months?

Person "A" to be insured

☐ No If *no*, you do not need to complete the rest of this question. Go to 5.2.

☐ Yes If *yes*, answer the following questions.

Person "B" to be insured

☐ No If *no*, you do not need to complete the rest of this question. Go to 5.2.

☐ Yes If *yes*, answer the following questions.

If *yes*, will you be travelling to a Caribbean or Mexican resort for less than four weeks, or travelling by cruise ship?

Person "A" to be insured

☐ No ☐ Yes

Person "B" to be insured

☐ No ☐ Yes

Do you have any other travel plans?

Person "A" to be insured

☐ No ☐ Yes If *yes*, provide details below.

Person "B" to be insured

☐ No ☐ Yes If *yes*, provide details below.

Person to be insured	Countries a cities will visit	Length of stay in each	Purpose of travel for each trip (Select all that apply.)
☐ Person "A" to be insured ☐ Person "B" to be insured			☐ for business ☐ as a tourist ☐ to visit family ☐ other: _____
☐ Person "A" to be insured ☐ Person "B" to be insured			☐ for business ☐ as a tourist ☐ to visit family ☐ other: _____
☐ Person "A" to be insured ☐ Person "B" to be insured			☐ for business ☐ as a tourist ☐ to visit family ☐ other: _____

5.2 Smoking and tobacco use

In the last 15 years, have you used or smoked any of the following?	Person "A" to be insured	If *yes*, provide details, including average amount used, how often, length of time used and the last date used.	Person "B" to be insured	If *yes*, provide details, including average amount used, how often, length of time used and the last date used.
a. Cigarettes	☐ No ☐ Yes		☐ No ☐ Yes	
b. Any form of marijuana (such as hashish)	☐ No ☐ Yes		☐ No ☐ Yes	
c. Cigars	☐ No ☐ Yes		☐ No ☐ Yes	
d. Pipe	☐ No ☐ Yes		☐ No ☐ Yes	
e. Cigarillos	☐ No ☐ Yes		☐ No ☐ Yes	
f. Chewing tobacco	☐ No ☐ Yes		☐ No ☐ Yes	
g. Nicotine substitutes (such as gum or patches)	☐ No ☐ Yes		☐ No ☐ Yes	
h. E-cigarettes	☐ No ☐ Yes		☐ No ☐ Yes	
i. Other _____ (specify) (Example: betel nuts, water pipe)	☐ No ☐ Yes		☐ No ☐ Yes	

Return sections 5 through 7 to: Manulife, 500 King Street North, PO BOX 1669, WATERLOO ON N2J 4Z6

Section 5 – Personal information (continued)

5.3 Alcohol and drug use

a. In the last 15 years, have you consumed alcohol?

Person "A" to be insured

☐ No If *no*, you do not need to complete the rest of question a. Go to question b.

☐ Yes If *yes*, answer the following question and provide details.

Do you currently drink alcohol?

☐ Yes If *yes*, provide details.

Beer	Number	bottles per	☐ day ☐ week ☐ month ☐ year
Wine	Number	glasses per	☐ day ☐ week ☐ month ☐ year
Liquor	Number	oz/ml per	☐ day ☐ week ☐ month ☐ year

☐ No If *no*, describe any past drinking behaviour, including why you stopped drinking.

Details

Person "B" to be insured

☐ No If *no*, you do not need to complete the rest of question a. Go to question b.

☐ Yes If *yes*, answer the following question and provide details.

Do you currently drink alcohol?

☐ Yes If *yes*, provide details.

Beer	Number	bottles per	☐ day ☐ week ☐ month ☐ year
Wine	Number	glasses per	☐ day ☐ week ☐ month ☐ year
Liquor	Number	oz/ml per	☐ day ☐ week ☐ month ☐ year

☐ No If *no*, describe any past drinking behaviour, including why you stopped drinking.

Details

b. In the last 15 years, have you used unprescribed drugs or experimented with drugs or narcotics such as ecstasy, cocaine, LSD, heroin, amphetamines, barbiturates, anabolic steroids or similar agents?

Person "A" to be insured

☐ No ☐ Yes If *yes*, provide details, including what you used, how often, and the last time you used it.

Details

Person "B" to be insured

☐ No ☐ Yes If *yes*, provide details, including what you used, how often, and the last time you used it.

Details

c. Have you ever been treated or counselled f hol or g abus r h om e eve commended that you seek treatment or counselling or reduce your alcohol or drug c mption?

Person "A" to be insured

☐ No ☐ Yes If *yes,* complete the alcohol usage section or drug usage section in *Underwriting questionnaires,* NN9434E, as applicable.

Person "B" to be insured

☐ No ☐ Yes If *yes,* complete the alcohol usage section or drug usage section in *Underwriting questionnaires,* NN9434E, as applicable.

5.4 Driving history

If you answer *yes* to any question in section 5.4, tell us the details below.	Person "A" to be insured	Person "B" to be insured
a. In the past two years, have you been charged with any motor vehicle or traffic violation (such as speeding, illegal lane changes or seatbelt violations)? If *yes*, provide details, including the number of charges and convictions and the date of the last conviction.	☐ No ☐ Yes	☐ No ☐ Yes
b. In the past five years, have you been charged with careless or dangerous driving or had your licence suspended or revoked? If *yes*, provide details, including the number of charges and convictions and the date of the last conviction. In the case of a licence suspension or revocation, provide details, including the date the licence was suspended or revoked.	☐ No ☐ Yes	☐ No ☐ Yes
c. In the past 10 years, have you been charged with refusing a breathalyzer test, or operating a motor vehicle either while impaired by alcohol or drugs or with a blood alcohol level over the legal limit? If *yes*, provide details, including the number of charges and convictions and the date of the last conviction.	☐ No ☐ Yes	☐ No ☐ Yes

Person to be insured	Question	Details (type of charge, number of charges, date) List all charges.
☐ Person "A" to be insured ☐ Person "B" to be insured		
☐ Person "A" to be insured ☐ Person "B" to be insured		
☐ Person "A" to be insured ☐ Person "B" to be insured		

Section 5 – Personal information (continued)

d. Do you have a driver's licence?

Person "A" to be insured

☐ No ☐ Yes If *yes,* tell us:

Driver's licence number	Where it was issued

Person "B" to be insured

☐ No ☐ Yes If *yes,* tell us:

Driver's licence number	Where it was issued

If you live in B.C., Manitoba, Quebec, N.W.T. or Yukon, and a motor vehicle record is required, you must also complete a *Motor vehicle record authorization* form.

5.5 Other information

If you answer *yes* to any question in section 5.5, tell us the details below.

	Person "A" to be insured	Person "B" to be insured
a. Have you ever had an application for life, disability, critical illness or long term care insurance declined, rated, postponed, cancelled or modified in any way? If *yes,* provide details, including the dates, name and type of coverage and the name of the insurance company.	☐ No ☐ Yes	☐ No ☐ Yes
b. Have you ever been charged with any criminal offence? If *yes*, provide details, including the nature of each offence, the date charged, the sentence and the date the sentence and any probation was completed.	☐ No ☐ Yes	☐ No ☐ Yes
c. In the past five years, have you flown in an aircraft as a pilot or do you expect to fly in an aircraft as a pilot? If *yes*, complete the applicable pages in *Underwriting questionnaires*, NN9434E.	☐ No ☐ Yes	☐ No ☐ Yes
d. In the past five years, have you participated in a hazardous sport or activity or do you expect to participate in a hazardous sport or activity, such as: • scuba or skin diving • mountain climbing • ballooning • skydiving • heli-skiing • hang gliding • ultralight flying • racing of any kind • back-country skiing, snowboarding or snowmobiling Other If *yes*, complete the applicable pages in *Underwriting questionnaires*, NN9434E.	☐ No ☐ Yes	☐ No ☐ Yes
e. In the past five years, have the people to be insured or the business had any major financial difficulties, such as having pay garnished, petitioning for bankruptcy or declaring bankruptcy? If *yes*, provide details, including the bankruptcy discharge date, if applicable.	☐ No ☐ Yes	☐ No ☐ Yes
f. Is a licence or permit required to operat[illegible] our bus[illegible]ss?	☐ No ☐ Yes	☐ No ☐ Yes
If *yes*, has any licence or permit ever been susp[illegible]ed or [illegible]oked, [illegible]ulating [illegible]ency [illegible]a complaint against you? If *yes*, provide details.	☐ No ☐ Yes	☐ No ☐ Yes
For life insurance policies only **g. Will the money to pay the premiums for this [illegible]cy be bo[illegible]ved [illegible]n an[illegible]ivid[illegible]a b[illegible]r other institution?** If *yes*, provide details.	☐ No ☐ Yes	☐ No ☐ Yes
For life insurance policies only **h. Is there an existing or planned agreement that provides for anyone other than an owner identified in this application to obtain any legal interest in any policy resulting from this application?** If *yes*, provide details.	☐ No ☐ Yes	☐ No ☐ Yes

Person to be insured	Question	Details
☐ Person "A" to be insured ☐ Person "B" to be insured		
☐ Person "A" to be insured ☐ Person "B" to be insured		
☐ Person "A" to be insured ☐ Person "B" to be insured		
☐ Person "A" to be insured ☐ Person "B" to be insured		
☐ Person "A" to be insured ☐ Person "B" to be insured		

5.6 Employment information

▶▶ **For any person to be insured who is applying only for a change to their disability insurance, complete section 11.1 *Employment history* instead.**

Person "A" to be insured

What is your occupation?	How long have you worked for your current employer?
Employer's name	
Employer's address (city, province)	

Person "B" to be insured

What is your occupation?	How long have you worked for your current employer?
Employer's name	
Employer's address (city, province)	

Section 5 – Personal information (continued)

5.7 Financial information

▶▶ **For any person to be insured who is only applying for a change to their disability insurance, complete section 11.2 *Financial information*.**
For all other insurance, if you have income or assets earned:
• within Canada, complete this section.
• outside of Canada, use *Financial questionnaire*, NN0781E.

	Person "A" to be insured	Person "B" to be insured
a. What is your annual earned income (within $10,000), including salary, commissions, dividends, bonuses and pension, within Canada?	$	$
b. What is your annual income (within $10,000) from other Canadian sources, including interest and income from real estate, within Canada?	$	$
c. If income is not generated from any of the above sources within Canada, tell us the household income.	$	$
d. What is your personal net worth? To calculate your personal net worth in Canada, add the value of your Canadian assets (such as cash, investments, personal property and real estate), and deduct your Canadian liabilities (any money you owe such as mortgages, loans and credit cards.)	$	$
e. Are you older than 70 and applying for insurance over $250,000? If *yes*, provide the required information in the following table:	☐ No ☐ Yes	☐ No ☐ Yes

Canadian assets		**Canadian liabilities**	
Value of primary residence	$	Mortgage	$
Registered investments	$	Other liabilities	$
Other investments and holdings	$		

▶▶ **If you are not adding or increasing insu ce, ou ar ly ap ng f a ch ge to -smoker, or if you are applying for a change from Healthstyl or ealths 3, you no ed comple the rest of section 5. Go to section 6.**

5.8 Business insurance

▶▶ **This section must be completed for all business insurance.**

	This year	Last year
a. What is the book value of the business (net worth)?	$	$
b. What is the fair market value of the business?	$	$
c. What is the gross annual revenue?	$	$
d. What is the net annual after-tax income?	$	$
e. What is the percentage of the business owned by Person "A" to be insured?	%	%
What is the percentage of the business owned by Person "B" to be insured?	%	%
f. Are other partners, owners and executives being insured?	☐ No ☐ Yes If *no,* provide details, including why not.	

5.9 Individual life insurance for a child

▶▶ **Complete this section only if you are applying to insure a child (17 years or younger) with an individual life insurance coverage (rather than a child rider).**

		Parent 1 (living with child)	Parent 2 (living with child)
a. What is the total amount of life insurance in effect on each of the child's parents?		$	$
b. What is the gross earned income of each of the child's parents?		$	$
c. How many siblings does the child have?			
d. How much insurance is in effect or pending on each sibling?	$	$	$

Section 6 – Height and weight

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider. All people to be insured must complete this section.

	Height	Weight	**Has your weight changed by more than 10 pounds (4.5 kg) in the past 12 months?** If *yes*, provide details, including the amount your weight changed and the reason. If the change resulted from pregnancy, tell us your pre-pregnancy weight.
Person "A" to be insured	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ No ☐ Yes
Person "B" to be insured	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ No ☐ Yes

Section 7 – Medical information

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider. All people to be insured must complete this section.

If you are providing medical information about a child to be insured, it is important that you have enough contact with the child to answer those questions reliably.

7.1 Doctor or clinic consultations

If you need additional space to describe your treatment, medications or information about doctor or clinic consultations, add these details in section 7.6.

a. Your regular family doctor or clinic

Do you have a family doctor or clinic that you use regularly?

Person "A" to be insured

☐ No ☐ Yes If *yes*, provide details of your family doctor or clinic.

Name of doctor (first, middle initial, last) or clinic		
Address		
City or town	Province	Telephone number ( )
Date last consulted in person, by phone, or by internet (dd/mmm/yyyy)		
Reason last consulted		
Name on file with doctor or clinic **(if different than legal name)**		
Treatment or medication prescribed and results of any tests completed		

Person "B" to be insured

☐ No ☐ Yes If *yes*, provide details of your family doctor or clinic.

Name of doctor (first, middle initial, last) or clinic		
Address		
City or town	Province	Telephone number ( )
Date last consulted in person, by phone, or by internet (dd/mmm/yyyy)		
Reason last consulted		
Name on file with doctor or clinic **(if different than legal name)**		
Treatment or medication prescribed and results of any tests completed		

b. Your recent doctor or clinic consultations

If you do not have a regular doctor or clinic, or if you have consulted a different doctor or clinic in person, by phone, or by internet since the consultation listed above, provide details about your last consultation.

Person "A" to be insured

Name of doctor (first, middle initial, last) or clinic		
Address		
City or town	Province	Telephone number ( )
Date last consulted (dd/mmm/yyyy)	Reason last consulted	
Name on file with doctor or clinic **(if different than legal name)**		
Treatment or medication prescribed and results of any tests completed		

Person "B" to be insured

Name of doctor (first, middle initial, last) or clinic		
Address		
City or town	Province	Telephone number ( )
Date last consulted (dd/mmm/yyyy)	Reason last consulted	
Name on file with doctor or clinic **(if different than legal name)**		
Treatment or medication prescribed and results of any tests completed		

Section 7 – Medical information (continued)

▶▶ If your advisor will have medical information collected by a paramedical service, go to section 8.

7.2 Your family medical history

a. Have either of your parents or a sibling been diagnosed before age 65 with any of the following conditions: heart disease, stroke or cancer?

Person "A" to be insured: ☐ No ☐ Yes ☐ unknown ▶ If *yes*, provide details in the chart below.
Person "B" to be insured: ☐ No ☐ Yes ☐ unknown ▶ If *yes*, provide details in the chart below.

b. Have either of your parents or a sibling ever been diagnosed with Huntington's chorea, polycystic kidney disease, Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, kidney disorders or retinitis pigmentosa?

Person "A" to be insured: ☐ No ☐ Yes ☐ unknown ▶ If *yes*, provide details in the chart below.
Person "B" to be insured: ☐ No ☐ Yes ☐ unknown ▶ If *yes*, provide details in the chart below.

Person to be insured	Relative's relationship to you	Condition or impairment (if cancer, provide details, including the type and location)	Age at onset
☐ Person "A" to be insured ☐ Person "B" to be insured			
☐ Person "A" to be insured ☐ Person "B" to be insured			
☐ Person "A" to be insured ☐ Person "B" to be insured			

7.3 Your medical history

If you answer *yes* to any question in section 7.3, tell us the details in section 7.6.

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

a. Do you have, have you been treated for, or have you been told you have any of the following conditions?	Person "A" to be insured	Person "B" to be insured
1. High blood pressure	☐ No ☐ Yes	☐ No ☐ Yes
2. High cholesterol	☐ No ☐ Yes	☐ No ☐ Yes
3. Cancer, tumours, leukemia, polyps or skin lesions	☐ No ☐ Yes	☐ No ☐ Yes
4. Diabetes (including gestational diabetes and impaired glucose tolerance)	☐ No ☐ Yes	☐ No ☐ Yes

b. Have you ever had or been told you had or been investigated or treated for conditions involving any of the following:	Person "A" to be insured	Person "B" to be insured
1. Your heart and blood vessels, such as: • angina • blood clots • bypass or angioplasty • heart disease • cerebrovascular disease (CVA) • chest pain or shortness of breath • claudication • heart attack (myocardial infarction) • heart murmur • pacemaker • palpitations or irregular pulse • peripheral vascular disease or peripheral artery disease • poor circulation • stroke or transient ischemic attack (TIA) • swollen ankles (other than due to pregnancy) other	☐ No ☐ Yes	☐ No ☐ Yes

Section 7 – Medical information (continued)

If you answer *yes* to any question in section 7.3, tell us the details in section 7.6.

c. Have you ever had or been told you had or been investigated or treated for conditions involving any of the following:	Person "A" to be insured	Person "B" to be insured
1. Your nose, throat or lungs, such as: • asthma • chronic bronchitis • sleep apnea • tuberculosis • chronic obstructive pulmonary disease (COPD) • cystic fibrosis • emphysema • sarcoidosis other	1. ☐ No ☐ Yes	☐ No ☐ Yes
2. Your abdominal organs, such as: • celiac disease • gastrointestinal reflux • irritable bowel syndrome • pancreatitis • cirrhosis • hepatitis (including active or carrier state) • liver disease • ulcer • colitis • Crohn's disease • diverticulitis • gastrointestinal bleeding • hiatus hernia • jaundice other	2. ☐ No ☐ Yes	☐ No ☐ Yes
3. Your kidneys, bladder or reproductive organs, such as: • abnormal Pap test • urinary tract infection (UTI) • other kidney or bladder disorders • bladder infection • kidney stone • nephritis • prostatitis or other prostate disorder • protein in the urine • uterine fibroids • polycystic kidney disease • sugar or blood in the urine • other reproductive disorder or sexually transmitted disease other	3. ☐ No ☐ Yes	☐ No ☐ Yes
4. Your breasts, such as: • abnormal mammogram findings or biopsy • lumps • other physical changes • cysts other	4. ☐ No ☐ Yes	☐ No ☐ Yes
5. Your nervous system, such as: • ALS or other motor neuron disease • Down syndrome • paral… • seiz… or co…sions • Alzheimer's disease • developmental de… • Parki…n's disea… • trer… • cerebral palsy • epilepsy • post-…cussion… • wert… • cognitive impairment • fainting or syncope • syndro… • bacte… …s • coma • loss of speech • dementia • migraine headaches • dizziness • multiple sclerosis • mental impairment other	5. ☐ No ☐ Yes	☐ No ☐ Yes
6. Your eyes or ears, such as: • blindness • impaired hearing • tinnitus • blurred or double vision • impaired sight • deafness • labyrinthitis • glaucoma • optic neuritis other	6. ☐ No ☐ Yes	☐ No ☐ Yes
7. Your mental health, such as: • anxiety • schizophrenia • attempted suicide • other psychological, behavioural, emotional or eating disorder • burnout • depression other	7. ☐ No ☐ Yes	☐ No ☐ Yes
8. Your glands or blood, such as: • abnormal blood sugar • lymph glands • anemia • thyroid disorders • bleeding tendency • other endocrine disorders • gout • hemophilia other	8. ☐ No ☐ Yes	☐ No ☐ Yes
9. Your muscles or bones, such as: • chronic fatigue • rheumatoid arthritis or osteoarthritis • any injury or disorder of the muscles, bones, joints or spine causing any physical limitations or restrictions • chronic pain syndrome • fibromyalgia • muscular dystrophy other	9. ☐ No ☐ Yes	☐ No ☐ Yes

Section 7 – Medical information (continued)

If you answer *yes* to any question in section 7.3, tell us the details in section 7.6.

	Person "A" to be insured	Person "B" to be insured
10. Your connective tissue, such as: • lupus • scleroderma other	10. ☐ No ☐ Yes	☐ No ☐ Yes
11. Your skin, such as: • basal cell carcinoma • nevus or nevi • dysplastic nevus syndrome • dermatitis • dysplastic nevus • psoriasis • lesions, freckles or moles that have changed in size, colour or have bled other	11. ☐ No ☐ Yes	☐ No ☐ Yes
12. Your immune system, such as: • HIV • AIDS other	12. ☐ No ☐ Yes	☐ No ☐ Yes
d. Has anyone ever recommended that you be tested for exposure to AIDS or HIV (other than for routine testing for pregnancy, blood donation, immigration or insurance), or do you have any reason to believe you have been exposed to the virus?	☐ No ☐ Yes	☐ No ☐ Yes
e. In the past five years, have you:		
1. had any medical or diagnostic tests, such as ECGs, X-rays, CT scans, Pap test, MRI, or blood tests? If *yes*, provide details of the test results.	☐ No ☐ Yes	☐ No ☐ Yes
2. had any illness or injury not already mentioned in this application?	☐ No ☐ Yes	☐ No ☐ Yes
3. had any surgery, hospital care, treatment, medical examination, diagnostic test or counselling not already mentioned in this application or that has been recommended but not yet taken place?	☐ No ☐ Yes	☐ No ☐ Yes
4. used any recommended medication not already mentioned in this application on a daily basis for more than three weeks (including prescription and non-prescription)?	☐ No ☐ Yes	☐ No ☐ Yes
5. consulted a counselor, health care worker, physician or therapist?	☐ No ☐ Yes	☐ No ☐ Yes
f. During the past 12 months, have you missed more than 15 consecutive days of work or school because of illness or injury?	☐ No ☐ Yes	☐ No ☐ Yes
g. Are you currently taking any prescribed medication, herbal or holistic treatment, or are you under observation for any condition other than those you have already told us about?	☐ No ☐ Yes	☐ No ☐ Yes
h. Are you currently disabled and unable to perform your regular occupation or regular activities?	☐ No ☐ Yes	☐ No ☐ Yes
i. Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐ No ☐ Yes	☐ No ☐ Yes
j. Are you pregnant? If *yes*, tell us your due date and the name and address of the attending doctor or health care worker.	☐ No ☐ Yes	☐ No ☐ Yes
1. What was your pre-pregnancy weight? ☐ lb ☐ kg		
2. Have there been any complications with your pregnancy? If *yes*, provide details.	☐ No ☐ Yes	☐ No ☐ Yes
k. Do you wear any device or use any application that helps you monitor wellness, health or a specific condition?	☐ No ☐ Yes	☐ No ☐ Yes

Section 7 – Medical information (continued)

7.4 Children under age 2 to be insured

▶▶ **Complete this section only if person "A" or "B" to be insured is under age 2. To apply for a child rider, use section 7.5 instead.**

If you answer *yes* to any question in section 7.4, tell us the details in section 7.6.

	Person "A" to be insured	Person "B" to be insured
a. Has the child had surgery or been hospitalized for more than 3 days at birth or later?	☐ No ☐ Yes	☐ No ☐ Yes
b. Was the child born prematurely (less than 36 weeks)?	☐ No ☐ Yes	☐ No ☐ Yes
c. Were there difficulties surrounding the birth or in the first six weeks after birth, congenital abnormalities, infectious disease or other health concerns?	☐ No ☐ Yes	☐ No ☐ Yes

7.5 Children to be insured under a child rider

▶▶ **Complete this section only if you are applying for a child rider. Otherwise go to next section.**

In this section, *you* and *your* refer to the people to be insured. The questions must be answered by the people to be insured. If a person to be insured is a minor, the minor's parent or guardian (tutor, in Quebec) must provide the information on their behalf.

It is important that you have enough contact with the child to answer these questions reliably.

If you answer *yes* to any question in section 7.5, tell us the details in section 7.6.

a. Height and weight

	Height	Weight	Has the child lost more than five pounds (2.3 kg) in the past 12 months? If *yes*, provide details, including the amount of weight lost and reason.
Name of child 1 under child rider:	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ No ☐ Yes
Name of child 2 under child rider:	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ No ☐ Yes
Name of child 3 under child rider:	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ No ☐ Yes
Name of child 4 under child rider:	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ No ☐ Yes

b. Medical information

	Child 1	Child 2	Child 3	Child 4
1. Has the child ever had or been told they had or been investigated or treated for conditions involving: cancer, heart disease or abnormality, kidney disease, diabetes, developmental disorder, or psychological impairment? If *yes,* provide details including the conditions, diagnosis if known, treatment history, names and addresses of all attending doctors, current state of health, and school attendance.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
2. Has the child ever been hospitalized for more than five consecutive days? If *yes*, provide details including the reason for hospitalization, dates, diagnosis if known, treatment history, names and addresses of all attending doctors, and current state of health.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
3. In the past five years, has the child used any prescribed medication on a daily basis for more than three weeks? Do not include vitamins, or any medications to treat skin, asthma or allergy. If *yes*, provide details including the reason for the medication, names and addresses of all attending doctors, and current state of health.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Section 7 – Medical information (continued)

7.6 Medical information details

If you have answered yes to any of the questions in sections 7.3, 7.4, or 7.5, tell us the details below. Include conditions, dates, durations, treatment, results and names and addresses of doctors, hospitals and clinics.

Person to be insured	Question	**Details, diagnosis if known, treatment history, testing dates, reason for tests, results of tests, recurrence and names and addresses of all attending doctors.** If you need additional space, you can use the back of page 35 or you can attach a separate sheet of paper that has been signed, dated and witnessed.
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		
☐ Person "A" ☐ Person "B" Name of child under child rider:		

Section 8 – Your other insurance policies

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider.

▶▶ **Do not complete this section if you are applying for a change to your disability insurance only. Instead complete section 11.3 *Your other disability insurance policies*.**

a. Other than group insurance, are any people to be insured covered under other life, critical illness, disability, or long term care insurance policies? Also include policies that: lapsed within the past 90 days, were sold to a third party, or were issued in another country.

☐ No ☐ Yes ▶ If *yes*, provide details.

* **For long term care policies:** Tell us the benefit amount and time period (for example, $75/day or $1,000/month).

Person to be insured	Name of insurance company and policy number	Year issued	Amount & type of insurance (life, critical illness, disability or long term care)	Lapsed or sold to a third party?	Personal or business?	Replacing?	Replacement form or LIRD completed, if applicable
☐ Person "A" ☐ Person "B" ☐ Child under a rider:	Name of insurance company Policy number		$ Type:	☐ lapsed ☐ sold to a third party	☐ personal ☐ business	☐ Yes ☐ No	☐ Yes ☐ No
☐ Person "A" ☐ Person "B" ☐ Child under a rider:	Name of insurance company Policy number		$ Type:	☐ lapsed ☐ sold to a third party	☐ personal ☐ business	☐ Yes ☐ No	☐ Yes ☐ No
☐ Person "A" ☐ Person "B" ☐ Child under a rider:	Name of insurance company Policy number		$ Type:	☐ lapsed ☐ sold to a third party	☐ personal ☐ business	☐ Yes ☐ No	☐ Yes ☐ No
☐ Person "A" ☐ Person "B" ☐ Child under a rider:	Name of insurance company Policy number		$ Type:	☐ lapsed ☐ sold to a third party	☐ personal ☐ business	☐ Yes ☐ No	☐ Yes ☐ No
☐ Person "A" ☐ Person "B" ☐ Child under a rider:	Name of insurance company Policy number		$ Type:	☐ lapsed ☐ sold to a third party	☐ personal ☐ business	☐ Yes ☐ No	☐ Yes ☐ No
☐ Person "A" ☐ Person "B" ☐ Child under a rider:	Name of insurance company Policy number		$ Type:	☐ lapsed ☐ sold to a third party	☐ personal ☐ business	☐ Yes ☐ No	☐ Yes ☐ No

In all provinces, if this application for insurance is to replace an existing life insurance coverage, complete and attach the required replacement disclosure forms.
In Quebec only, if this application for insurance is to replace an existing critical illness insurance coverage, complete and attach the required replacement disclosure forms.

You must also complete all necessary forms to cancel the existing policy.

b. Have you applied for any other insurance that has not yet been issued? Include life, critical illness, disability, or long term care insurance.

☐ No ☐ Yes ▶ If *yes*, provide details.

Person to be insured	Name of insurance company	Reference number	Amount & type of insurance (life, critical illness, disability or long term care)	Personal or business?
☐ Person "A" ☐ Person "B" ☐ Child under a rider:			$ Type:	☐ personal ☐ business
☐ Person "A" ☐ Person "B" ☐ Child under a rider:			$ Type:	☐ personal ☐ business
☐ Person "A" ☐ Person "B" ☐ Child under a rider:			$ Type:	☐ personal ☐ business

Section 9 – Information about your new policy

▶▶ Complete this section only if you are converting term insurance, exercising a GIO or BVP, or cancelling a joint last-to-die UltraVision policy and issuing a new current-dated single life policy(ies).

In this section, *Policy 1* refers to the policy that contains the term insurance or child rider to be converted, the guaranteed insurability option (GIO) or the business value protector (BVP) option or the joint last-to-die UltraVision policy to be cancelled. *Policy 2* and *new policy* refer to the policy that will contain the new insurance after it is converted, purchased through an option or issued.

The new policy (Policy 2) may be a new policy or an existing policy. In some cases, Policy 1 and Policy 2 may be the same policy.

We, *us* and *our* refer to The Manufacturers Life Insurance Company.
You and *your* refer to the owner of Policy 1, except where otherwise specified.

9.1 Policy ownership for the new policy

▶▶ Complete this section only if the new insurance will be issued on a new policy.

If you do not complete this section, the owner of the new policy will be the owner of Policy 1.

If the new policy will be a universal life or whole life policy, tell us the social insurance number of the owner of the new policy in the box provided.

Who will own the new policy?

☐ same as owner of Policy 1, **OR** ☐ same as Person "A" to be insured in section 3, Social insurance number **OR**

☐ same as Person "B" to be insured in section 3 Social insurance number **OR**

☐ provided below

Owner #1

Legal name (first, middle initial, last)			Sex ☐ male ☐ female
Date of birth (dd/mmm/yyyy)	Social insurance number (if owner of a universal life or whole life policy)	Relationship to person to be insured	
Home address (number, street and unit)	City or town	Province	Postal code

OR

Full name of legal entity such as company or trust (including Company, Limited, Inc., etc.)			
Company department to receive correspondence about this policy (Example: Accounts payable)			Business number (BN from Canada Revenue Agency)
Address (number, street and unit)	City or town	Province	Postal code

Your business number is the identification number you use for tax purposes. Under the *Income Tax Act*, we are required to record a business number if the policy is owned by an entity.

Owner #2

Legal name (first, middle initial, last)			Sex ☐ male ☐ female
Date of birth (dd/mmm/yyyy)	Social insurance number (if owner of a universal life or whole life policy)	Relationship to person to be insured	
Home address (number, street and unit)	City or town	Province	Postal code

OR

Full name of legal entity such as company or trust (including Company, Limited, Inc., etc.)			
Company department to receive correspondence about this policy (Example: Accounts payable)			Business number (BN from Canada Revenue Agency)
Address (number, street and unit)	City or town	Province	Postal code

Your business number is the identification number you use for tax purposes. Under the *Income Tax Act*, we are required to record a business number if the policy is owned by an entity.

9.2 Multiple owners

In all provinces except Quebec

If the new policy will be owned by more than one person, we will set it up as *joint ownership with right of survivorship*. This means policy ownership is shared between the joint policy owners and, if the policy is still in effect after the death of one of the joint owners, that owner's share automatically passes to the surviving joint owner or owners.

If you want ownership of your policy to be set up as *tenants in common* instead of *joint ownership with right of survivorship*, select *tenants in common* below.

☐ tenants in common (If you select this option, complete and submit *Establishing tenants in common ownership for a policy*, NN0967E.)

In Quebec

If the new policy will be owned by more than one person, and if the policy is still in effect after the death of one of the owners, that owner's interest will pass to their estate unless a subrogated policy owner has been named for that person's interest in the policy.

Section 9 – Information about your new policy (continued)

9.3 Naming a successor owner or subrogated policy owner

In all provinces except Quebec

If there is only one owner and the policy may continue after that owner's death, identifying another person to take over ownership results in a faster and easier transfer. For critical illness or disability policies, this section only applies if the legislation in your jurisdiction allows you to name a successor owner.

Name of owner	Name of successor owner (first, middle initial, last)	Relationship to owner

In Quebec

If the policy may continue after any policy owner's death, identifying another person to take over ownership results in a faster and easier transfer.

Name of owner	Name of subrogated owner for owner #1 (first, middle initial, last)	Relationship of subrogated owner to owner #1
Name of owner	Name of subrogated owner for owner #2 (first, middle initial, last)	Relationship of subrogated owner to owner #2

9.4 Billing information for the new policy

In this section, *you* and *your* refer to the new policy owner or the account holder unless otherwise specified.

▶▶ **If you are adding insurance to an existing policy, you do not need to complete this section. Your billing information for the existing policy will not change.**

a. Your first payment

1. What is the amount of your first payment?

Amount
$

If you're making your first payment by pre-authorized debit, you must write the amount of the first payment in this box.

2. How is the first payment being made?

If you are paying by cheque, the cheque must be in Canadian funds drawn on a Canadian bank or financial institution and made payable to Manulife. We do **not** accept cash.

☐ by cheque with this application (The cheque must be dated with the same date as this application.)
☐ use premium refund from Policy 1
☐ by pre-authorized debit ▶ Complete section 9.5 *Banking information*
☐ with funds from a policy insured by Manulife as follows:

Take the payment from the policy as

☐ dividends ☐ a loan ☐ part of the policy's cash value up to 90% of cash value)

Policy number	Name of person (first, middle initial, last) insured under the policy	Amount you are transferring
		$

By signing below you agree that:
- you are entitled to receive the proceeds of the policy you've identified above
- the policy is insured by a Manulife company, and
- you direct that company to withdraw the amount of money identified above and transfer it to the company that will insure the policy you are applying for in this application.

If the policy owner is a corporation, we require the signatures and titles of two corporate signing officers or the signature and title of one signing officer and the corporate seal. If the corporation does not have a corporate seal and you are the only person authorized to sign on behalf of the corporation, sign in the box for owner of the policy from which the funds are transferred and write your initials in the box provided.

Signature of owner of the policy from which the funds are transferred ✘	Date (dd/mmm/yyyy)
Signature of owner of the policy from which the funds are transferred ✘	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.
Signature of collateral assignee/hypothecary creditor (if applicable) ✘	Date (dd/mmm/yyyy)
Signature of irrevocable beneficiary (if applicable) ✘	Date (dd/mmm/yyyy)

Section 9 – Information about your new policy (continued)

b. Your regular payments

1. How will your regular payments be made?

If you are paying by cheque, the cheque must be in Canadian funds drawn on a Canadian bank or financial institution and made payable to Manulife. We do **not** accept cash.

If the information you provide here is different than the information you provide in the product page for the product you are applying for, we will use the information in the product page.

☐ monthly by pre-authorized debit using the banking information in section 9.5 ☐ annually by cheque

Your monthly payment	Extra payment amount	Your total monthly payment
$	$	$

For universal life or Performax Gold policies only

☐ calculate the minimum payment **OR** ☐ the total planned deposit or additional payment is $

c. Who will be making your payments?

Select each person associated with the bank account from which the payments will be made.

☐ Owner #1 ☐ Owner #2 ☐ Person "A" to be insured ☐ Person "B" to be insured

Complete the following if any payor or joint bank account holder is not:

- **an owner of the insurance policy, or**
- **one of the people to be insured.**

Account holder #1

Name (first, middle initial, last or full name of legal entity, including Company, Limited, Inc., etc.)		Relationship to policy owner	
Address (number, street and unit)	City or town	Province	Postal code

Account holder #2

Name (first, middle initial, last or full name of legal entity, including Company, Limited, Inc., etc.)		Relationship to policy owner	
Address (number, street and unit)	City or town	Province	Postal code

9.5 Banking information

In this section *you* and *your* refer to the account holder(s) of the bank account from which withdrawals will be made.

▶▶ **Complete this section if you are making any payments by pre-authorized debit.**

Do you want to add to an existing plan or set up a new one?

☐ add to existing plan

Policy number on which the current monthly pre-authorized debit plan is set up

☐ set up a **new** monthly pre-authorized debit using the banking information below

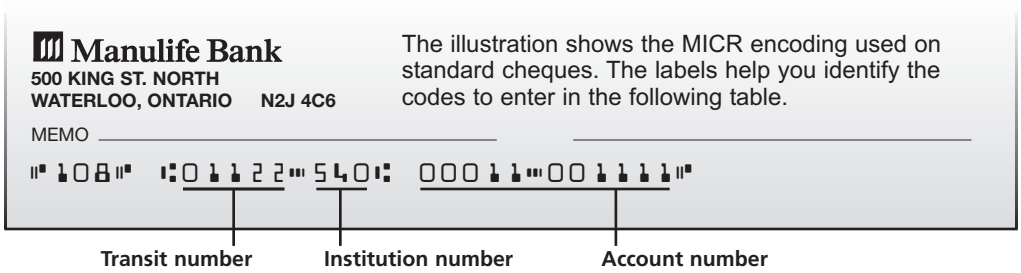
Withdrawal date for monthly pre-authorized debit (1st through 28th)

What banking information should we use?

☐ from the cheque used to make the first payment

☐ from the attached void cheque (Attach the cheque to this page, immediately below. You can cover both the image and the following table.)

☐ as follows: (Only complete the table below if you do not have a void cheque)



The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.

Name of Canadian bank or financial institution	Transit number	Institution number	Account number

Section 9 – Information about your new policy (continued)

9.6 Authorizing pre-authorized debits from your bank account

In this section *you* and *your* refer to the account holder(s) of the bank account from which withdrawals will be made.

If the policy owner, insured person, or payor is making the pre-authorized debit payments, their signature in section 12 means that they have read and agree to the authorizations here.

By asking us to take payments from your bank account, you agree that you have read and agree to the following information:

Authorizing the first payment withdrawal from your bank account
By asking us to make a pre-authorized debit for the first payment, you agree that:

- you authorize us to make one withdrawal from your bank account for the amount of your first payment as shown in Section 9.5
- this payment may be withdrawn from your bank account as soon as you submit this application to us
- if this payment is not honoured by your bank or financial institution:
  - we will not attempt to withdraw it again,
  - any temporary or conditional insurance certificate is not in effect, and
  - you must pay your first premium when we deliver the policy
- **you waive the right to receive 10 days' notice of the pre-authorized debit to be made from your account for your first payment.**

The pre-authorized debit for your first payment will be treated as a personal pre-authorized debit (PAD) as defined by the Canadian Payments Association in Rule H1 at www.payments.ca.

Authorizing variable amount monthly pre-authorized debits to make your subsequent payments

By asking us to establish a monthly pre-authorized debit plan to make your subsequent payments, you agree to the following:

- you authorize us to make monthly withdrawals from your bank account to pay for the policy
- except as otherwise stated in this agreement, the withdrawals will occur on the date that you specified above
- the withdrawals from your bank account are in variable amounts. In certain circumstances, we may increase these withdrawals to administer your policy. (Example: if the premium for the policy is scheduled to change.)
- if you have a policy with insufficient account value to cover the monthly deduction, we will not increase the payments withdrawn from your bank account to prevent your policy from terminating, and
- **you waive the right to receive 10 days' notice of the amount and date of each monthly pre-authorized debit to be made from your account.**

The pre-authorized debit for monthly payments will be treated as a personal pre-authorized debit (PAD) as defined by the Canadian Payments Association in Rule H1 at www.payments.ca.

What we will do if your bank or financial institution does not honour a monthly pre-authorized debit

If your bank or financial institution does not honour a monthly pre-authorized debit the first time we present it for payment, we may attempt to withdraw that payment again within 30 days.

If that withdrawal is not honoured, we may attempt to withdraw that amount again together with your next month's monthly pre-authorized debit.

We reserve the right to end the monthly pre-authorized debit plan immediately if a withdrawal is not honoured.

Making changes to your monthly pre-authorized debit plan

You can request changes to the amount of the monthly pre-authorized debit or the account from which the monthly pre-authorized debit is being taken by telephone or in writing. We must receive the request at least three days before the monthly pre-authorized debit date. The advisor for this policy can also make these changes on your behalf.

Universal life or Whole life policies

For universal life or whole life policies, we have the right to change your monthly pre-authorized debit date to be at least four days before your policy processing day.

Personal withdrawals

All monthly pre-authorized debits from your bank account will be treated as personal pre-authorized debits (PADs) as defined by the Canadian Payments Association in Rule H1 at www.payments.ca.

Cancelling this agreement

You or we can end this agreement at any time by giving 10 days' written notice, counted from the date the notice is mailed. For a sample cancellation form or more information about cancelling a monthly pre-authorized debit plan, contact your bank or financial institution or visit www.payments.ca.

Unauthorized withdrawals

You have certain recourse rights if any withdrawal does not comply with this agreement. For example, you have the right to receive reimbursement for any withdrawal that is not authorized or is not consistent with this agreement. To obtain more information on your recourse rights, contact your bank or financial institution or visit www.payments.ca.

Your personal information

You authorize us to collect, use, release and exchange any personal information necessary to fulfill any obligations relating to withdrawals made from your bank account.

For more information about pre-authorized debits from your bank account

If you have any questions or concerns about pre-authorized debits from your bank account, contact us using the contact information on page 40 of this application, in the section titled *How we resolve complaints*.

For more information about your rights, contact your bank or financial institution or the Canadian Payments Association at www.payments.ca.

Certification

You certify that all people whose signatures are required on this account have signed in section 12, including any required joint account holders or corporate signing officers.

9.7 Acknowledgment and consent

In this section *you* and *your* mean the people to be insured, the owner(s) of Policy 1 and Policy 2, the parent or guardian (tutor, in Quebec) of any children to be insured who are under age 16 (under age 18 in Quebec) and any collateral assignee, hypothecary creditor or irrevocable beneficiary.

The *original insurer* refers to the company that issued or insures Policy 1.

By signing in section 12 of this form, you consent to the conversion of insurance or exercise of the option or rider as described in this application, and

- you authorize the original insurer to release all information connected with Policy 1 to us and applicable reinsurers and authorize us to use it as described in section 12,
- you agree that if we issue new insurance under the terms of this application, the effective date of the new insurance will be shown in Policy 2,
- you agree that the new insurance that comes into effect as a result of this application satisfies the original insurer's obligation to provide additional insurance under the original policy; the original insurer is released from this obligation to the same extent that the original insurer would have been released if they had provided the new insurance,
- you acknowledge that on the effective date of the new insurance, the coverage you are converting and any coverage you ask us to cancel will be cancelled; depending on the amount of insurance you are converting and cancelling, this may mean that Policy 1 will terminate,
- if you are converting insurance, purchasing insurance under a child rider, exercising a GIO or BVP option or cancelling a joint last-to-die UltraVision policy and issuing new single life policy(ies), you acknowledge that the time limits for contestability and suicide run from the later of the date the new insurance is issued or last reinstated,
- if you are a collateral assignee (hypothecary creditor, in Quebec), you acknowledge that we will not be bound with respect to Policy 2 until we receive a copy of the new assignment or hypothec of Policy 2 at our head office,
- if you are an irrevocable beneficiary, you acknowledge that your rights under Policy 1 will only be carried forward into Policy 2 if you are designated as an irrevocable beneficiary in Policy 2,
- if you own Policy 1 but not Policy 2, you acknowledge that you do not gain any ownership rights in Policy 2 as a result of this conversion or exercise,
- if the owner of Policy 2 is different than the owner of Policy 1, and Policy 2 is a Performax Gold or universal life policy, you acknowledge that any accumulated additional payment or deposit room in Policy 1 does not carry forward to Policy 2.

Section 10 – Temporary life and critical illness insurance questions

In this section, *you* and *your* refer to the people to be insured.

▶▶ Complete this section if you have chosen one of the following options in section 1 and you want to apply for temporary life or temporary critical illness insurance on the person to be insured:

- **Add a coverage**
- **Add a new insured person**
- **Increase amount of insurance**

Temporary insurance can apply to an individual life.

10.1 Eligibility for temporary life insurance

Only people from the ages of 15 days to 75 years inclusive are eligible for temporary life insurance.

Each person to be insured under the policy who is applying for temporary life insurance must answer the following questions.	Person "A" to be insured	Person "B" to be insured
a. In the past 12 months, have you consulted a doctor or other health practitioner for, been treated for or had any indication of heart attack, cancer, stroke, AIDS or HIV?	☐ No ☐ Yes	☐ No ☐ Yes
b. In the past 60 days, have you consulted a doctor or other health practitioner and been told to have a further examination, diagnostic test or surgery which has not been performed, or for which the results are not known (other than pregnancy or childbirth)?	☐ No ☐ Yes	☐ No ☐ Yes

If a person to be insured answers *yes* to either question a or b above, that person is **not** eligible for temporary life insurance.

If a person to be insured answers *no* to questions a and b above, and if the conditions described on the *Temporary life insurance certificate* are met, temporary life insurance coverage for that person begins when we receive payment.

The *Temporary life insurance certificate* on pages 27 and 28 explains your coverage.

10.2 Eligibility for temporary critical illness insurance

▶▶ Do not complete this section if you are applying for a change to a Synergy solution. Temporary critical illness insurance is not offered with Synergy.

Only people from the ages of 18 years to 60 ye inclusi re eligibl for tempora itical ill in nce.

Each person to be insured under the policy who pply for te rary c al illn insu e m nswer the following questions.

	Person "A" to be insured	Person "B" to be insured
a. Do you have, or have you ever consulted a docto ner heal ractitio or, n tre d for c d any indication of: • heart or blood vessel disease, heart attack, chest pain • stroke or transient ischemic attacks • diabetes • cancer or tumours • chronic kidney, liver or lung disease • blindness, deafness • loss of limbs • severe burns • AIDS or HIV • cognitive impairment, coma, loss of speech, multiple sclerosis, paralysis, Parkinson's disease, dementia, Alzheimer's disease	☐ No ☐ Yes	☐ No ☐ Yes
b. In the past two years, have you been refused coverage for life, critical illness, disability or long term care insurance or been offered insurance with restricted benefits or at higher than standard rates?	☐ No ☐ Yes	☐ No ☐ Yes
c. In the past 60 days, have you been admitted or advised to be admitted to a hospital or clinic, other than for pregnancy or childbirth?	☐ No ☐ Yes	☐ No ☐ Yes
d. In the past 60 days, have you consulted a doctor or other health practitioner and been told to have a further examination, diagnostic test or surgery which has not been performed, or for which the results are not known (other than pregnancy or childbirth)?	☐ No ☐ Yes	☐ No ☐ Yes

If a person to be insured answers *yes* to any of questions a – d above, that person is **not** eligible for temporary critical illness insurance.

If a person to be insured answers *no* to questions a – d above, and if the conditions described on the *Temporary critical illness insurance certificate* are met, temporary critical illness insurance coverage for that person begins when we receive payment.

The *Temporary critical illness insurance certificate* on pages 27 and 28 explains your coverage.

10.3 Instructions for the advisor

Leave unused temporary insurance certificates attached to this application.

If any of the people to be insured are eligible for temporary insurance (that is, meet **all** the conditions on the applicable temporary insurance certificates on the following pages):

- accept payment for the full amount of the first premium on the policy:
  - for payment by a new pre-authorized debit, complete section 9.5, including the amount of the first payment
  - for payment by cheque, give the policy owner the receipt for payment. The cheque must be dated the same day as this application.
- give the policy owner the applicable certificate
- if all the applicable conditions are met, tell the policy owner that temporary insurance for the eligible people to be insured begins when the payment is honoured by the bank or financial institution.

Otherwise, do not accept payment.

Manulife

Temporary life insurance certificate

In this certificate:

- *we*, *us* and *our* mean The Manufacturers Life Insurance Company
- *you* and *your* mean the policy owner
- *insured person* means a person listed in section 3 of this application as a person to be insured, and does not include children to be insured under a child rider
- *this application* means the *Application for change* with the same number that appears in the top right corner of this page
- *this agreement* means this temporary life insurance certificate.

Conditions

If you are applying for a change to an UltraVision policy, temporary life insurance is not offered. Subject to the terms and conditions of this agreement, we agree to provide temporary life insurance coverage on each insured person who meets the following requirements:

- the insured person answered *no* to questions a) and b) in section 10.1 and
- the age of the insured person is from 15 days to 75 years inclusive.

This agreement will take effect if the following conditions are satisfied:

- you and the person(s) to be insured complete and sign the *Application for change*
- when this *Application for change* is submitted, you provide us with a cheque or authorization for a pre-authorized debit from your account
- the payment we receive for the additional coverage applied for is enough to pay for that coverage until the next premium due date. It is not necessary to make a payment:
  - if the policy being changed is a universal life policy, and
  - if the payment we received for your existing policy is enough to also pay for the additional coverage applied for until the next premium due date
- the bank or financial institution honours the payment when we first present it and
- no information has been misrepresented or left out of this application, including information about children to be insured under a child rider, that would affect our decision to provide insurance or the terms under which we provide it.

These conditions are not met, this agreement will not take effect. No person may change this agreement in any way.

Temporary life insurance

1. The temporary life insurance coverage for an insured person will be in the same amount (subject to the maximum amount specified below) and of the same type (single life, joint first-to-die or joint last-to-die) as that applied for under this *Application for change* with respect to that insured person.
2. The terms of this temporary life insurance agreement do not apply if you have applied for any of the following:
   - reinstatement of a lapsed policy
   - insurance through a "portability" or "conversion" provision of an existing policy
   - insurance through a "purchase of new policy" or "conversion" option of a supplemental benefit or rider, including a "survivor's benefit".

continued on the back

Detach and leave with the policy owner

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Manulife

Temporary critical illness insurance certificate

In this certificate:

- *we, us* and *our* mean the Manufacturers Life Insurance Company
- *you* and *your* mean the policy owner
- *insured person* means a person listed in section 3 of this application as a person to be insured, and does not include children to be insured under a child rider
- *this application* means the *Application for change* with the same number that appears in the top right corner of this page
- *this agreement* means this temporary critical illness insurance certificate
- *covered condition* means a condition as defined in the **Covered conditions** section of the standard policy contract
- *definite diagnosis* means the written statement by a specialist, supported by the appropriate investigation and medical evidence, that the insured person meets the definition of a covered condition in the standard policy contract
- *specialist* means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered condition for the benefit that is being claimed, and who has been certified by a specialty examining board. If a specialist is not available, an appropriate condition may be diagnosed by a qualified medical practitioner practising in Canada or the United States. Examples of specialists are included in the standard policy contract. The specialist must not be the policy owner, the insured person or a relative or business associate of the owner or the insured person.
- *satisfy* or *satisfies* means that the insured person must be living and meets all the requirements in the policy for the benefit they are claiming. *Additional information on the meaning of this word can be found in the standard policy contract*.
- *standard policy contract* means the standard policy contract offered by us for sale on the date of this *Application for change*, for the type of critical illness insurance applied for on this *Application for change*. You can obtain the standard policy contract from your advisor or at www.manulife.ca/b4ubuy.

Conditions

If you are applying for a change to a Synergy solution, temporary critical illness insurance is not offered.

Subject to the terms and conditions of this agreement, we agree to provide temporary critical illness insurance coverage on each insured person who meets the following requirements:

- the insured person answered *no* to questions a), b), c) and d) in section 10.2 and
- the age of the insured person is from 18 years to 60 years inclusive.

This agreement will take effect if the following requirements are satisfied:

- you and the person(s) to be insured complete and sign the *Application for change*
- when this *Application for change* is submitted, you provide us with a cheque or authorization for a pre-authorized debit from your account
- the payment we receive when this *Application for change* is completed for additional coverage is enough to pay for the additional coverage applied for until the next premium due date
- the bank or financial institution honours the payment when we first present it and
- no information has been misrepresented or left out of this *Application for change*, including information about children to be insured under a child rider, that would affect our decision to provide insurance or the terms under which we provide it.

If these conditions are not met, this agreement will not take effect. No person may change this agreement in any way.

Temporary critical illness insurance

The temporary critical illness insurance under this agreement covers all of the covered conditions included in the coverage you applied for, as defined in the **Covered conditions** section of the standard policy contract, except for the covered conditions specifically excluded in **Exclusions and limitations**, below.

1. We will pay a benefit to you on the occurrence of a covered condition if:
   - the definite diagnosis of the covered condition occurs while this agreement is in effect
   - the terms of this agreement are met

continued on the back

Temporary life insurance certificate (continued)

In these cases, the terms of the provision, benefit or rider apply.

3. If you have applied to change joint last-to-die coverage on the insured person, no benefit under that coverage will be paid with respect to the death of that insured person unless all people insured under that joint last-to-die coverage die while this agreement is in effect.
4. The combined maximum benefit payable for any insured person under all temporary life and critical illness insurance agreements with us is the amount of insurance, including accidental death benefits, applied for on that insured person or $1,000,000, whichever less.
5. With respect to the maximum benefit payable an insu person, the benefit payable under any temporary critical ill insu e agre will take precedence over any benefit payable u r thi reeme
6. If the total amount of life insurance you've applie on an insu person is greater than the maximum allowable und agreem nd that insured person dies while covered under this a ment, we w refund the portion of any premium you've paid for coverage for that insured person over their allowable maximum.
7. The beneficiary under this agreement will be the beneficiary named for that insured person in this *Application for change*.
8. The temporary life insurance outlined in this agreement will end on the earliest of:
   - the date we deliver a contractual document as a result of this *Application for change*
   - the date we mail you a notice that we have declined your *Application for change*
   - the date we mail you a notice that the insurance under this agreement has been cancelled
   - 90 days from the date this *Application for change* was signed.

   This agreement terminates on the date specified above regardless of whether we have refunded the premium that you paid with this *Application for change*.
9. If we issue a life insurance policy to you based on the terms of this *Application for change*, we will apply your first premium payment to the pre ns due under t olicy. If we decline your *Application for change*, or if we offer a policy based on terms other than those outl in yo on for change* and you do not accept the policy, we refu our remium payment.

   Ins nce provid overage over the maximum allowable, inc ng accide death benefit, takes effect:
   - w we ntractual document to you, and
   - when you have paid the new amount sufficient to provide coverage under the changed policy to the next premium due date, and
   - if the health or insurability of the people to be insured under the policy has not worsened between the time this *Application for change* was completed and delivery of the contractual document.

Exclusions and limitations

If an insured person commits suicide, whether sane or insane, we will not pay a death benefit for that insured person. We will refund the premium you paid for life insurance coverage for that insured person and all coverage for that insured person under this agreement will end.

Temporary critical illness insurance certificate (continued)

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   - the insured person satisfies all the criteria for the diagnosed covered condition and
   - the insured person has satisfied the waiting period for the diagnosed covered condition as defined in the standard policy contract.
2. The amount of the benefit payable under this agreement is the amount of Lifecheque coverage you have applied for on the insured person, subject to:
   - the maximum benefit amounts established by this agreement and
   - any other exclusions and limitations in this agreement.
3. The maximum benefit for any insured person under all temporary critical illness insurance agreements with us is the total amount of critical illness insurance coverage applied for on that insured person or $500,000, whichever is less.
4. The combined maximum benefit for any insur erson er all life critical illness temporary insurance agreements h us e amo insurance applied for on that person, including a den eath b fits, or $1,000,000, whichever is less.
5. In determining the maximum benefit payable for a red perso e benefit payable under this agreement will take prece ce over any benefit payable under a temporary life insurance agreement.
6. If we pay a benefit to you under this agreement, we will refund any premium collected for insurance coverage that exceeds our maximum benefit payable under this agreement for that insured person.
7. Temporary critical illness insurance coverage on the insured person ends on the earliest of:
   - the date we deliver a contractual document as a result of this *Application for change*
   - the date we mail you a notice that we have declined your application for critical illness insurance
   - the date when a benefit is payable under this agreement
   - the date we mail you a notice that the insurance under this agreement has been cancelled
   - 90 days from the date you sign this *Application for change*, unless the insured person has been given a definite diagnosis of a covered condition and is in the waiting period for that condition, in which case the temporary critical illness insurance coverage on the insured person:
     - will be limited to that condition and
     - will end on the date the insured person is no longer satisfying the waiting period for that condition.

   This agreement terminates on the date specified above regardless of whether we have refunded the premium that you paid with this *Appl tion for chang*
8. If we issue a critical il s policy to you based on the terms of this *Appl tion* e will apply your first premium payment to the pre ns under t olicy. If we decline your application, or if we offe u a tractua cument based on terms other than those outl in *Appli on for change* and you do not accept the con ual d will refund your first premium payment.

Exclusions and limitations

No LivingCare benefit, early intervention benefit or recovery benefit is payable under this agreement.

The exclusions and limitations described throughout the standard policy contract apply.

No payment will be made under this agreement for the covered conditions cancer and benign brain tumour, as defined in the standard policy contract.

Void

Section 11 – Information required for disability policies

In this section, *you* and *your* refer to the person to be insured, unless otherwise specified.

▶▶ **Complete this section if you are applying for a change to a disability insurance policy.**
▶▶ **Do not complete if you are applying for a change to a Synergy solution.**

11.1 Employment history	**Person "A" to be insured**	**Person "B" to be insured**
a. Occupation		
b. Professional designation/Degree		
c. How many years have you worked in this occupation? If less than two years, tell us your former occupation		
d. Name and address of employer (if you are an employee) or **Name and address of business (if you are self-employed)**	Name of employer/business Address of employer/business	Name of employer/business Address of employer/business
e. What is the nature of the business?		
f. If you are self-employed, provide the following details.	Number of partners/principals Number of full-time employees Number of part-time employees	Number of partners/principals Number of full-time employees Number of part-time employees
g. How many years/months have you been with this employer or been self-employed?		
h. How many hours do you work per week?		
i. Do you work less than 10 months a year?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.
j. Job duties – Describe your job duties and indicate the percentage of time spent performing each duty:	% of time spent / Description of duties	% of time spent / Description of duties
1. Manual or physical	%	%
2. Administration or office	%	%
3. Sales	%	%
4. Supervision: office (including executive or professional)	%	%
Supervision: shop or plant	%	%
Supervision: on site	%	%
k. Are you aware of any changes that will occur within the next 12 months that will change your duties or employment status?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.
l. Do you have any part-time employment?	☐ No ☐ Yes If *yes*, tell us: Occupation Annual net income $ Duties	☐ No ☐ Yes If *yes*, tell us: Occupation Annual net income $ Duties
m. Have you ever received or requested a pension, disability benefits, compensation or been off work for more than 10 days, for any accident or sickness?	☐ No ☐ Yes If *yes*, provide details:	☐ No ☐ Yes If *yes*, provide details:
n. Do you work at home?	☐ No ☐ Yes If *yes*, answer questions 1-3 below.	☐ No ☐ Yes If *yes*, answer questions 1-3 below.
1. Number of hours you work from home.	Number of hours per ☐ day or ☐ week	Number of hours per ☐ day or ☐ week
2. Is your home workplace open to the public?	☐ No ☐ Yes	☐ No ☐ Yes
3. Do you have employees other than family members working in your home?	☐ No ☐ Yes	☐ No ☐ Yes

Section 11 – Information required for disability policies (continued)

11.2 Financial information

Answer the following questions for all people to be insured. All questions must be answered even if you submit financial reports.

	Person "A" to be insured	Person "B" to be insured
a. What is your current employment status? Select all that apply	☐ **Employee** (if your declared net income is on lines 101 and 104 on your income tax return) ☐ **Commissioned sales** (if your declared net income is on lines 101 plus 104 minus line 229 of your income tax return) ☐ **Sole proprietor** (if your declared net income is on lines 135-143 of your income tax return) Fiscal year-end (dd/mmm) ☐ **Partner** (if your declared net income is on lines 135-143 of your income tax return) Percentage of ownership % | Fiscal year-end (dd/mmm) ☐ **Incorporated** (if your declared net income is on lines 101 and 104 of your income tax return, plus your share of the corporate profits or losses) Percentage of ownership % | Fiscal year-end (dd/mmm)	☐ **Employee** (if your declared net income is on lines 101 and 104 on your income tax return) ☐ **Commissioned sales** (if your declared net income is on lines 101 plus 104 minus line 229 of your income tax return) ☐ **Sole proprietor** (if your declared net income is on lines 135-143 of your income tax return) Fiscal year-end (dd/mmm) ☐ **Partner** (if your declared net income is on lines 135-143 of your income tax return) Percentage of ownership % | Fiscal year-end (dd/mmm) ☐ **Incorporated** (if your declared net income is on lines 101 and 104 of your income tax return, plus your share of the corporate profits or losses) Percentage of ownership % | Fiscal year-end (dd/mmm)
b. What was your insurable net annual earned income for last year and two years ago? Include income from all sources identified above. **Insurable net annual earned income:** your net annual earned income after allowable business expenses are deducted, but before taxes, as declared to Canada Revenue Agency.	**Last year** Year | $ **Two years ago** Year | $	**Last year** Year | $ **Two years ago** Year | $
c. If you are self-employed, do you split your income for tax purposes? Attach a copy of your spouse's T4, with their authorization for our collection, use and retention of this information.	☐ No ☐ Yes If *yes*, tell us the amount on your spouse's T4. **Last year** Year | $ **Two years ago** Year | $	☐ No ☐ Yes If *yes*, tell us the amount on your spouse's T4. **Last year** Year | $ **Two years ago** Year | $
d. Do you expect that your insurable net annual earned income for this year will be less than 80% of last year's income?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.
e. Have you changed your employment status(es) in the past 12 months?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.
f. Calculate your unearned income for last year and estimate it for this year. Do either of those figures exceed the lesser of $30,000 or 15% of your insurable net annual earned income? **Unearned income:** income that is **not** dependent upon your ability to work (Example: investment income, rental income, royalties, pension or similar income.)	☐ No ☐ Yes If *yes*, provide details. Current year | Prior year Dividends $ | $ Interest $ | $ Pension $ | $ Capital gains $ | $ Net rental $ | $ Other $ | $ **Total** $ | $	☐ No ☐ Yes If *yes*, provide details. Current year | Prior year Dividends $ | $ Interest $ | $ Pension $ | $ Capital gains $ | $ Net rental $ | $ Other $ | $ **Total** $ | $

Section 11 – Information required for disability policies (continued)

	Person "A" to be insured	Person "B" to be insured
g. Does your net worth exceed $5,000,000? **Net worth:** the value of your assets minus your liabilities.	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.

	Person "A" to be insured	Person "B" to be insured
	Assets	**Assets**
Residence	$	$
Other real estate	$	$
Personal property	$	$
Equity in business or practice	$	$
Cash, stock, bonds	$	$
Other	$	$
Total	$	$
	Liabilities	**Liabilities**
Residence mortgage	$	$
Other mortgages	$	$
Bank loans	$	$
Other	$	$
Total	$	$
	Total Net Worth	**Total Net Worth**
Total assets minus total liabilities =	$	$

11.3 Your other disability insurance policies

	Person "A" to be insured	Person "B" to be insured
a. Are you eligible for employment insurance?	☐ No ☐ Yes	☐ No ☐ Yes
b. Are you eligible for workers' compensation?	☐ No ☐ Yes	☐ No ☐ Yes
c. Do you have any other disability insurance in effect or pending? Include individual, group, association, creditor insurance, salary continuation, accident only, overhead expense or disability buy-sell or any other type of insurance which provides disability benefits issued or pending in any country.	☐ No ☐ Yes If *yes*, complete chart below.	☐ No ☐ Yes If *yes*, complete chart below.

Person to be insured	Name of insurance company	Pending No	Pending Yes	Issue date (mmm/yyyy)	Monthly benefit amount	Elimination period	Benefit period	Income replacement	Buy-Sell	Overhead	Taxable benefits? No	Taxable benefits? Yes	Is insurance being replaced? No	Is insurance being replaced? Yes
☐ Person A ☐ Person B		☐	☐		$			☐	☐	☐	☐	☐	☐	☐
☐ Person A ☐ Person B		☐	☐		$			☐	☐	☐	☐	☐	☐	☐
☐ Person A ☐ Person B		☐	☐		$			☐	☐	☐	☐	☐	☐	☐
☐ Person A ☐ Person B		☐	☐		$			☐	☐	☐	☐	☐	☐	☐

In Quebec only, if this application for insurance is to replace an existing disability insurance coverage, complete and attach the required replacement disclosure forms.

You must also complete all necessary forms to cancel the existing policy.

Section 11 – Information required for disability policies (continued)

11.4 For health care professionals

	Person "A" to be insured	Person "B" to be insured
If you are a health care professional, have you been successfully vaccinated against hepatitis B?	☐ No If *no*, provide details. ☐ Yes If *yes*, provide date.	☐ No If *no*, provide details. ☐ Yes If *yes*, provide date.

11.5 Back pain questionnaire

a. About your back health	Person "A" to be insured	Person "B" to be insured
1. Have you had or been told you had or been investigated or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain or sciatica?	☐ No ☐ Yes	☐ No ☐ Yes
2. In the past five years, have you ever consulted a chiropractor?	☐ No ☐ Yes	☐ No ☐ Yes

If a person to be insured answers *yes* to either question 1 or 2 above, complete the rest of 11.5.
If a person to be insured answers *no* to both questions 1 and 2 above, go to 11.6.

b. Have you ever experienced pain or discomfort in your back?	☐ No ☐ Yes	☐ No ☐ Yes
c. What area of the back was involved?	☐ neck (cervical) ☐ middle (thoracic) ☐ low (lumbar)	☐ neck (cervical) ☐ middle (thoracic) ☐ low (lumbar)
d. What was the pain caused by?	☐ disc problem ☐ muscular problem ☐ nerve(s) problem	☐ disc problem ☐ muscular problem ☐ nerve(s) problem
e. What was the date your first episode occurred?	Date first episode occurred (mmm/yyyy)	First episode occurred (mmm/yyyy)
1. How long did the symptoms persist?	From (mmm/yyyy) To (mmm/yyyy)	From (mmm/yyyy) To (mmm/yyyy)
2. Were you off work?	☐ No ☐ Yes If *yes*, provide details including length of time off work.	☐ No ☐ Yes If *yes*, provide details including length of time off work.
f. Have there been any recurrences?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.
1. Tell us the dates and duration of each recurrence	Dates and duration of each recurrence	Dates and duration of each recurrence
2. Were you off work?	☐ No ☐ Yes If *yes*, provide details including length of time off work.	☐ No ☐ Yes If *yes*, provide details including length of time off work.
g. When did you last experience back pain or discomfort?	Date (mmm/yyyy)	Date (mmm/yyyy)
h. What treatment and/or tests including X-rays have you undergone? (Include dates and duration and exact tests, results and/or treatment given)		

Section 11 – Information required for disability policies (continued)

	Person "A" to be insured	Person "B" to be insured
i. Names and addresses of health professionals consulted.	Name of medical doctor	Name of medical doctor
	Address	Address
	Name of chiropractor	Name of chiropractor
	Address	Address
	Name of other health professional	Name of other health professional
	Type of health professional/Specialty	Type of health professional/Specialty
	Address	Address
j. Do you have any limitation or restriction of back movement?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.
1. Does the limitation or restriction of back movement limit your ability to perform your work?	☐ No ☐ Yes If *yes*, provide details.	☐ No ☐ Yes If *yes*, provide details.

11.6 Overhead expenses

▶▶ If applying for a change to ExpenseComp ility pol ans all fol ing q ions for all people to be insured. Complete this section even if you are subm ng financia .

	Person "A" to be insured	Person "B" to be insured
a. How many people share the expenses?		
b. What proportion of the expenses do you pay? (If there are more than four partners, include a copy of the expense-sharing agreement.)		
c. What is the total number of employees?	Total number of employees	Total number of employees
1. Tell us the position and the number of employees in each position (Example: Reception: 2; Accounting clerk: 1; etc.)	Position and number of people in that position	Position and number of people in that position
	Position and number of people in that position	Position and number of people in that position
	Position and number of people in that position	Position and number of people in that position
	Position and number of people in that position	Position and number of people in that position
	Position and number of people in that position	Position and number of people in that position
	Position and number of people in that position	Position and number of people in that position

Section 11 – Information required for disability policies (continued)

d. What are the average monthly expenses incurred in the operation of the office?

Do **not** include expenses incurred for:

- the purpose of acquiring goods for sale, supplies or additions to inventory
- salaries, fees, drawing account or renumeration for: the person to be insured, any member of the person to be insured's profession or related profession, any person sharing the business expenses of the person to be insured
- travel and/or entertainment.

Expenses	Person "A" to be insured – Your share	Person "B" to be insured – Your share
1. a. Rent or		
b. Property taxes and mortgage interest payments plus depreciation or principal payments		
2. Office maintenance		
3. Public utilities (heat, water, electricity)		
4. Telephone, postage, paging, fax, and answering service		
5. Employee salaries and benefits (except as described in the margin)		
6. M…gement c…pany fee (excluding family…ned firm)		
7. Ac…nting s…es		
8. Pro…onal …ciation …mbersh…es		
9. Prope…an…ability in…nce pren…s		
10. a. Leas…pment o…		
b. Interest payments **plus** t…er of sched…d depr…n …principal payments for equipment		
11. Interest plus principal payments for business loans from a financial institution to purchase business		
12. Other fixed monthly expenses (normal and customary):		
a.		
b.		
Total		

Section 12 – Authorizations, agreements and signatures

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 application. You may not alter any of the wording in section 12. Any attempt to do so will be of no effect. If you wish to withdraw your consent or opt out of direct marketing, see the relevant section below.

In this statement, *you* and *your* refer to the policy owner or holder of rights under the policy, the life insured, and the parent or guardian (tutor, in Quebec) of any child named as life insured who is under the age of 16 (or under 18 in Quebec). *We*, *us*, *our*, and *the Company* refer to The Manufacturers Life Insurance Company, and our affiliated companies and subsidiaries.

Updates to this statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify, and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- identifying information, such as your name, address, telephone number(s), email address, your date of birth, driver's license, passport number, or Social Insurance Number (SIN)
- medical information that any organization or person has about you
- any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test
- your personal information from MIB, Inc. as explained in Information about MIB, Inc.
- a copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- a personal investigation, financial information, credit bureau report, and/or a consumer report from other organizations, person, or source that has any information or records about you
- information about how you use our products and services, and information about your preferences, demographics, and interests
- other personal information we may require to administer our business relationship with you.

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

We collect your personal information from:

- your completed applications, recorded teleinterviews, and forms
- other interactions between you and the Company
- other sources, such as:
  - your advisor or authorized representative(s)
  - third parties with whom we deal in issuing and administering your policy now, and in the future
  - public sources, such as government agencies, or internet sites.

What do we use your personal information for?

We will use your personal information to:

- help us properly administer the products and services that we provide and to manage our relationship with you
- confirm your identity and the accuracy of the information you provide
- evaluate your application and issue and administer the rights under the policy
- comply with legal and regulatory requirements
- understand more about you and how you like to do business with us
- analyze data to help us understand our customers better so we can improve the products and services we provide
- determine your eligibility for, and provide you with details of, other products or services that may be of interest to you.

Who do we disclose your information to?

We disclose your information to:

- persons, financial institutions, and other parties with whom we deal in issuing and administering your policy now, and in the future
- authorized employees, agents, and representatives
- your advisor and any agency that has entered into an agreement with us and has supervisory authority, directly or indirectly over your advisor, and their employees
- any person or organization to whom you gave consent
- people who are legally authorized to view your personal information
- service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical, and investigative agencies)
- your medical doctor

Section 12 – Authorizations, agreements and signatures (continued)

- public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease.

The abovementioned people, organizations, and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:

- will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- will be shared with all the owners and any subsequent owners of those contracts and all people to be insured.

How long do we keep your information?

We keep your information the longer of:

- the time period required by law and by guidelines set for the financial services industry,

  or

- the time period required to administer the products and services we provide.

If your application is declined, the authorizations, agreements, and consent that you provide throughout this application continue in effect.

Withdrawing consent

You may withdraw your consent for us to use your SIN or Business Number, if applicable, for non-tax administration purposes. You may also withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain, or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the policy or we may treat your withdrawal of consent as a request to terminate the policy.

If you wish to withdraw your consent, phone our customer care centre at 1-888-MANULIFE (626- 8543), or 1-888-MANUVIE (626-8843) in Quebec, or write to the Privacy Officer.

Accuracy and Access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question, a concern, or wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
500 King Street N.
Waterloo, ON N2J 4C6
Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Opting out of direct marketing

You have the right to opt out of additional product offerings. By withdrawing your consent for us to use your personal information for the purpose of marketing, you understand it will not affect our ability to continue to provide you with the products and services you have requested, but it will exclude you from receiving direct personalized marketing or special offers on other products and services.

How we resolve complaints

To discuss any questions or concerns you may have, please contact your advisor or our head office at:
1-888-626-8543 in all provinces except Quebec or
1-888-6[illegible]8843 in Quebec

More information about our complaint resolution process is available on the Internet at www.manulife.ca under Contact Us > Complaint resolution.

If your policy or any rider that provides a death benefit contains a suicide provision

You agree that the amount payable on the death of an insured person who commits suicide will be determined as follows:

a. If the suicide of an insured person occurs **within the time period** stipulated in the suicide provision, we will pay the amount described in that provision.

b. If the suicide of an insured person occurs **after the time period** stipulated in the suicide provision, but within two years of the issue date of

   - an increase in the amount of insurance for that person on the policy or on a rider or
   - the addition of a rider relating to that insured person if that rider provides a death benefit,

   we will pay the amount described in the death benefit provision as if the increase or addition had not occurred. We will also return any premium amounts paid, or cost of insurance deducted, for that increase or addition.

Section 12 – Authorizations, agreements and signatures (continued)

Terms for issuing policy changes

A policy change takes effect when
- any payment due to us as a result of the change has been paid and
- the change is approved by us at our head office provided there has been no change in the insurability of the insured person or people since the application was completed.

The *Income Tax Act* (Canada) introduced new tax rules for life insurance policies that are effective January 1, 2017. If your policy was issued before that date, it may be subject to the new tax rules if you make a change that takes effect on or after January 1, 2017 and if that change:
- requires medical underwriting, or
- results in a new policy or coverage being issued.

A policy that becomes subject to the new rules may require a withdrawal to keep its exempt status and the withdrawal could increase your taxable income. If we cannot adjust your policy to maintain its exempt status, it may become non-exempt.

Talk to your advisor and be sure you understand the tax consequences of any change to your policy.

This application includes the pages numbered 1 to 41 plus all written statements submitted in connection with it.

By signing on page 38 or 39, you agree that

- You ask us to make changes/additions to policy 1 as shown in section 1 of this application. You authorize us to amend the policy or issue a replacement policy if necessary.
- We can void any change within two years after the change is made if a person to be insured or policy owner states a material fact incorrectly or fraudulently, misrepresents or fails to disclose any fact which would have affected our decision to allow the change or the premium to be charged after the change, whether the misrepresentation or lack of disclosure occurs in:
  - the *Application for change* or
  - any medical evidence form or
  - any written statement or answers provided as evidence of insurability.

  If an insured person dies during those two years, we can contest at any time. We can also contest at any time with respect to a misstatement of age, a total disability benefit, or fraud.
- When you take delivery of the changed policy or any document endorsing the change you have requested, you agree to its terms, including any changes we have made to the terms. These changes may affect the amount or timing of benefits that become payable on the policy, or the expiry date of the coverage.
- You understand that the authorizations you provide will remain in effect after the policy owner and the people to be insured die so we can evaluate and review any claim under the policy.
- If the premium or cost of insurance for this policy increases as a result of this application for change, the owners of the bank account from which withdrawals will be made authorize us to increase the monthly pre-authorized debit to cover the amount of the cost increase. They waive the right to receive 10 days written notice of such an increase.
- For universal life or whole life policies, we have the right to change your monthly pre-authorized debit date to be at least four days before your policy year date.
- For reinstatements, if the premiums or payments for the policy are paid by monthly pre-authorized debit, and
  - the policy lapsed within the past three months, we will resume the monthly pre-authorized debit plan. The owner(s) of the bank account from which withdrawals will be made **must sign in section 12** to authorize us to increase the monthly withdrawal by the new amount required to keep the policy in effect as a result of this policy change or reinstatement.
  - the policy lapsed more than three months ago, the payor must complete *Request to change or create a new automatic monthly withdrawal plan*, NN0312E to confirm the monthly pre-authorized debit plan details for the reinstated policy.

Section 12 – Authorizations, agreements and signatures (continued)

Signatures for Policy 1

Review this application, including the authorizations and agreements on pages 35, 36, and 37 and sign below.

By signing below you are confirming that:

- you have read the application and confirm that the statements in it are complete, current and accurate to the best of your knowledge and belief. You will immediately notify us of any errors or omissions
- if you have completed section 9 for a term conversion, to exercise a GIO or BVP option or to cancel a joint last-to-die UltraVision policy and issue a new current-dated single life policy(ies), you acknowledge and consent to the terms in section 9
- if this application results in a new policy, you have read and understood the final version of the policy illustration (if one is required), including the fact that some values may not be guaranteed. You will contact us immediately if you have any concerns regarding your illustration
- if you are eligible for temporary insurance, you have read and understood the *Temporary life insurance certificate* and/or the *Temporary critical illness insurance certificate* (see pages 27 and 28) and you understand that the temporary insurance applies only to those people to be insured who meet all of the conditions for eligibility, regardless of the amount of premium paid with this application
- you agree to the terms and conditions described in this application
- a copy of this authorization and agreement is as valid as the original document
- your signature has been witnessed in person by an independent third party of legal age who is unrelated to the applicants and does not stand to benefit from the insurance applied for. Examples of potential witnesses might include your advisor, the paramed nurse, a neighbour, or a friend.

Note: If the policy owner is a corporation, we require the signatures and titles of two signing officers or the signature and title of one signing officer and the corporate seal. If the corporation does not have a corporate seal and you are the only person authorized to sign on behalf of the corporation, sign in the box for owner of policy 1 and write your initials in the box provided.

Signed at (city or town, province)	Date (dd/mmm/yyyy – for example, 23/JUL/2017)
Name of witness (if not advisor)	

Signature of Person "A" to be insured ✘	Signature of witness ✘
Signature of Person "B" to be insured ✘	Signature of witness ✘

Signature of child to be insured if age 16 or over (all pr… except Q…ec) ✘	…atu… wit…

Signature of owner of policy 1 (if not Person "A" or "B") ✘	Title (if the policy is owned by a business)
Signature of owner of policy 1 (if not Person "A" or "B") ✘	Title (if the policy is owned by a business)
Signature of witness ✘	

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.

Signature of collateral assignee/hypothecary creditor of Policy 1 ✘	Title (if signing for a corporation)	Signature of witness ✘
Signature of collateral assignee/hypothecary creditor of Policy 1 ✘	Title (if signing for a corporation)	Signature of witness ✘

Signature of irrevocable beneficiary of Policy 1 (if applicable) ✘	Signature of witness ✘

If a person to be insured is under age 16 (under age 18 in Quebec), the mother, father or guardian (if they are not also a policy owner) must sign below to consent to this application for insurance.

Relationship to the person to be insured: ☐ mother ☐ father ☐ guardian (tutor in Quebec)

Signature of parent or guardian (tutor in Quebec) ✘	Signature of witness ✘

Section 12 – Authorizations, agreements and signatures (continued)

Your advisor's access to your personal information

Do you authorize Manulife to share the following information with your advisor if that information affects your application:

- our findings concerning your blood pressure, cholesterol level or physical build, and
- any information provided in this application, or in any telephone interview or paramedical interview?

Person "A" to be insured ☐ Yes ☐ No Person "B" to be insured ☐ Yes ☐ No

If you do not answer this question, we will share this information with your advisor. Your advisor may use this information to discuss your insurance options with you.

Signatures for Policy 2

See section 9 for a description of Policy 2.

Signature of owner of Policy 2 (if not an owner of Policy 1) ✘	Title (if signing for a corporation)	Signature of witness ✘
Signature of owner of Policy 2 (if not an owner of Policy 1) ✘	Title (if signing for a corporation)	Signature of witness ✘
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.

Signature of collateral assignee/hypothecary creditor for Policy 2 (if Policy 2 is an existing policy) ✘	Title (if signing for a corporation)	Signature of witness ✘
Signature of collateral assignee/hypothecary creditor for Policy 2 (if Policy 2 is an existing policy) ✘	Title (if signing for a corporation)	Signature of witness ✘
Signature of irrevocable beneficiary for Policy 2 (if applicable) ✘		

Authorizing pre-authorized debits from your bank account

▶▶ **Do not sign below if you are an insured person or owner of Policy 1 or Policy 2.**

▶▶ **Sign below if you are the account holder(s) of the bank account from which the first payment withdrawal and subsequent automatic withdrawals will be made and you are not an insured person or an owner of Policy 1 or Policy 2 and:**

- **you are asking us to establish a monthly pre-authorized debit plan or**
- **the monthly pre-authorized debits for this policy are increasing as a result of the policy change requested or**
- **the monthly pre-authorized debits for this policy are resuming as a result of the reinstatement requested.**

- If withdrawals are to be made from a joint account and your bank or financial institution requires both signatures, both account holders must sign.
- If withdrawals are to be made from a corporate account, identify the corporate account and provide the signatures and titles of two corporate signing officers or the signature and title of one signing officer and the corporate seal. If the corporation does not have a corporate seal and you are the only person authorized to sign on behalf of the corporation, sign in the box for account holder #1 and write your initials in the box provided.

By signing below, you confirm that you have read and agree to the authorizations in section 9.7.

Name of account holder #1 or corporate signing officer #1 (if not a person to be insured or the policy owner)	
Signature of account holder #1 ✘	Title (if applicable)

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.

Name of account holder #2 or corporate signing officer #2 (if not a person to be insured or the policy owner)	
Signature of account holder #2 ✘	Title (if applicable)

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intentionally.

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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, MIB, Inc. and any other organization, institution, association or person that has information, records or knowledge of you or your insurability, or of your children or their insurability (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 insurability information to MIB, Inc.

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

Relationship to the person to be insured

☐ mother ☐ father ☐ (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, MIB, Inc. and any other organization, institution, association or person that has information, records or knowledge of you or your insurability, or of your children or their insurability (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 insurability information to MIB, Inc.

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 $

By signing below, the advisor confirms that this payment for the insurance applied for in the application, 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

Information about MIB, Inc.

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, Inc. (formerly known as the Medical Information Bureau) based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made.

MIB, Inc. is a non-profit organization set up by life insurance companies to share information with its members. If you apply for insurance or submit a claim to a member company, MIB, Inc. will disclose any information it has on file.

You may review the information in your file, and request a correction if necessary by contacting MIB, Inc. at

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

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Your right to access your personal information

You can ask to review your personal information in our files and have any inaccuracies corrected by sending a written request to:

Privacy office - Individual Insurance, 500 King St. N.,
PO Box 1669, Kitchener ON N2J 4Z6

Where you can find more information about our privacy policy

To obtain a copy of our policies and practices for handling personal information, contact our privacy office at the address above, or visit www.manulife.ca and search for "privacy".

##########

How we resolve complaints

We're delighted that you are interested in purchasing an insurance product from us and we're committed to continually affirming your confidence in us in the years to come. If you have any concerns with the product or with the service you receive, you can rest assured that we will handle all of your questions and concerns fairly and efficiently.

To discuss any questions or concerns you may have, contact your advisor or our head office at

1-888-626-8543 in all provinces except Quebec, or

1-888-626-8843 in Quebec.

For more information about our complaint resolution process, visit www.manulife.ca and search for "complaint resolution".

Advisor's report

In this report, *you* and *your* refer to the advisor who is selling the insurance coverage.

1 Advisor information

a. List the advisors involved in this sale or policy change.
If the servicing advisor shown is not the original servicing advisor, we will update our records to use the servicing advisor shown here. Only the original advisor can submit applications for a plan exchange or change.

1. Name of **servicing** advisor (first, middle initial, last)		
Advisor code	Branch code	Percentage of commission %

2. Name of advisor (first, middle initial, last)		
Advisor code	Branch code	Percentage of commission %

3. Name of advisor (first, middle initial, last)		
Advisor code	Branch code	Percentage of commission %

2 About the people to be insured

a. How long have you known the people to be insured?

Person "A" to be insured	Person "B" to be insured
☐ years ☐ months	☐ years ☐ months

b. Is the person to be insured an advisor or an immediate family member of an advisor? ☐ No ☐ Yes

c. Which underwriting requirements have you requested for the people being insured? Select all that apply.

	Person "A" to be insured	Person "B" to be insured
Paramedical	☐	☐
Medical by physician	☐	☐
Medical by internist or cardiologist	☐	☐
Insurance blood profile	☐	☐
Height, weight, blood pressure	☐	☐
Micro-urinalysis	☐	☐
Electro-cardiogram	☐	☐
Chest X-ray	☐	☐
Treadmill stress test	☐	☐

	Person "A" to be insured	Person "B" to be insured
Inspection report	☐	☐
Medshare		
Carrier (Person "A" to be insured)		
Carrier (Person "B" to be insured)		
Other:	☐	☐
	☐	☐

What vendor did you use for these requirements? Name

d. Is/are the owner and person(s) to be insured fluent in the language of this application?
Owner ☐ No ☐ Yes
Person "A" to be insured ☐ No ☐ Yes
Person "B" to be insured ☐ No ☐ Yes

If *no*, tell us what language(s) the person(s) identified above are fluent in and describe the steps that were taken to ensure that they understood the questions and authorizations in this application.

e. Did you complete this application in person with the person(s) to be insured and the owner(s)?
☐ No ☐ Yes

If *no*, provide details including how the application was completed and who completed the application.

3 General information

a. If the person to be insured qualifies for a Healthstyle that is better than the Healthstyle you illustrated, tell us what you want us to do.

- ☐ issue the policy with the amount of insurance illustrated (the premium will be lower than the premium illustrated)
- ☐ increase the amount of insurance to an amount that keeps the same premium illustrated and issue the policy with the improved Healthstyle (the amount of insurance will increase but the premium will remain the same as the premium illustrated)
- ☐ increase the amount of insurance to an amount that is within the age and amount requirements (the premium will increase and financial underwriting will be required before the new amount of insurance is approved)

b. Tell us any other information that may be useful in reviewing this application as well as any special policy date or other requests.

4 Advisor's certification

By signing below:

- **you confirm that you hold all necessary ...enses a... certificates to write this application ...change in your jurisdiction and the jurisdiction where the policy owner resi...**
- if this application includes a universal life or v...le li...olicy,
  - you verify that you have reviewed the origi... v... and u...pired id...y d...me... and any ...er information provided by all owners, signing officers or trustees
  - you agree to tell us if you suspect that some... who has no... ...tified ...the a... ...m or product page form will be:
    - paying for or making deposits to the policy
    - making decisions about or participating in any way in the policy
    - expecting to benefit in any way from the policy

  (You can email us through the Repsource secure inbox at amlatf_office_canadian_division@manulife.com or complete *Report to Individual Insurance Compliance*, NN1557E and mail or fax it to us.)
- if this policy is replacing another policy, you confirm that you have made the proper disclosures to your client and have completed the appropriate replacement documents and, if necessary, you have provided these documents to us
- you confirm that you have disclosed the following information to the owner of this policy:
  - the name of the company or companies you represent
  - that you receive commissions for the sale of life and living benefits 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 ✘	Email address or telephone number for advisor