Manulife Financial

DECLARATION OF INSURABILITY FOR REINSTATEMENT OR CHANGE

Affinity Markets
Certificate/Policy Number(s): _____

Association: _____

Agent Name: _____ Agent Number: _____

Full Name of Applicant	Place of Birth	Date of Birth (dd/mm/yy)	**Height & Weight**	**Sex**
			_____ ☐ ft/in ☐ cm _____ ☐ lbs ☐ kg	

Dependent Information (Complete only if Reinstatement or Change applies to any coverage on Dependents)

Full Name of Spouse	Place of Birth	Date of Birth (dd/mm/yy)	_____ ☐ ft/in ☐ cm _____ ☐ lbs ☐ kg	
Full Name of Dependent Child	Place of Birth	Date of Birth (dd/mm/yy)	_____ ☐ ft/in ☐ cm _____ ☐ lbs ☐ kg	
Full Name of Dependent Child	Place of Birth	Date of Birth (dd/mm/yy)	_____ ☐ ft/in ☐ cm _____ ☐ lbs ☐ kg	
Full Name of Dependent Child	Place of Birth	Date of Birth (dd/mm/yy)	_____ ☐ ft/in ☐ cm _____ ☐ lbs ☐ kg	

Residence Address - Street/Apt. No. | City/Town | Province/Territory | Postal Code

(_____) _____ (_____) _____

Residence Telephone Number | Cellular Telephone Number | E-mail Address

Name and address of Owner if different than the Applicant: _____

I/We hereby request:

i) Reinstatement of coverage ☐
ii) A change to coverage ☐
in accordance with following instructions:

IMPORTANT:

If requesting reconsideration of an exclusion or rating, please provide full details regarding the excluded condition(s) or condition(s), which resulted in the rating. _____

Send the completed form to:

The Manufacturers Life Insurance Company
Affinity Markets
2 Queen Street East
PO Box 4213 STN A
Toronto ON M5W 5M3

PLEASE COMPLETE QUESTIONS 1 TO 4 FOR ALL INSUREDS

	Applicant		Spouse		Dependent Child	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**
1. Since the date of the application have you or any dependent:						
a) participated in hazardous sports or flown in any type of aircraft for reasons other than as a fare paying passenger?	☐	☐	☐	☐	☐	☐
b) applied for life or disability/health coverage which is presently pending or had any application for insurance declined, postponed, or modified?	☐	☐	☐	☐	☐	☐
c) made a claim or received a pension for any sickness, accident or injury?	☐	☐	☐	☐	☐	☐
d) missed more than 2 weeks from work/school due to any injury, disease or disorder?	☐	☐	☐	☐	☐	☐
e) received treatment or advice because of alcohol or drugs, or used any illegal or habit forming drugs?	☐	☐	☐	☐	☐	☐
f) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other diseases or disorder of the immune system?	☐	☐	☐	☐	☐	☐
g) consulted any doctor for treatment or testing for any injuries, diseases or disorders?	☐	☐	☐	☐	☐	☐
h) had any abnormalities on blood or other testing, or visited any specialist, or been hospitalized or institutionalized?	☐	☐	☐	☐	☐	☐
i) been advised to have an investigation, which has not yet been done?	☐	☐	☐	☐	☐	☐
2. Have you consulted any medical practitioner in the past year or do you have a regular attending physician? ***IF YES***, Name & Address of doctor, date last seen, reason, results, degree of recovery & current status. ***Please identify the insured.***	☐	☐	☐	☐	☐	☐
3. Are you or any dependent listed currently using or expect to be using any medication or serum? ***IF YES***, please provide full details, medications, monthly cost, and strength of medication, daily dosage, and length of time on this medication. ***Please identify the insured.***	☐	☐	☐	☐	☐	☐
4. a) Do you presently or have you in the past 12 months used tobacco in any form? If yes, indicate the type of tobacco used and the quantity daily.	☐	☐	☐	☐	☐	☐
b) Have you ever been advised by a physician to reduce or eliminate your use of tobacco for medical reasons?	☐	☐	☐	☐	☐	☐
c) Have you previously used tobacco in any form? If yes, what type of tobacco did you use and when was your last use?	☐	☐	☐	☐	☐	☐

PLEASE COMPLETE QUESTION 5 IF APPLYING FOR REINSTATEMENT OR CHANGE TO A DISABILITY CERTIFICATE/POLICY.

5. a) Occupation: _____		
b) Employer: _____		
c) Are you now actively and have you been consistently working on a full-time basis? **(If No, give details below)**	☐	☐
d) Average net monthly income (after business expenses, before taxes) earned over the past 12 months?		

(Please provide complete copies of your last years personal and corporate (if applicable) tax returns, financial statements and notice of assessment if applying to reinstate any disability insurance).

Declarations and Authorizations

1. I/we declare that the statements contained in this application, including the Health Declaration originally attached hereto, are true and complete. I/we understand that this application, together with any other forms signed by me/us in connection with this application, forms the basis for any certificate issued hereunder.
2. The person(s) to be insured understand(s) that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I/we understand that exclusions and limitations apply to the coverage applied for. Relative to the insurance applied for, I/we, the person(s) to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the Medical Information Bureau, the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me/us or my/our health or the health of any member of my/our family to be insured under this plan to provide to Manulife Financial or its reinsurers any such information for the purpose of this application and contract and any subsequent claim.
3. I/we authorize Manulife Financial to consult its existing files for this purpose.
4. I/we authorize Manulife Financial, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me/us their products or services. I/we understand that my/our consent to the use of such information to offer me/us products or services is optional and that if I/we wish to discontinue such use I/we may write to Manulife Financial at the address shown on this document.
5. A photocopy or faxed copy of this authorization shall be as valid as the original.
6. I acknowledge receipt of, and confirm my agreement with, the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.
7. I (the member) hereby designate the individual(s) named as beneficiary to receive the proceeds payable upon my or my spouse's death.
8. I/we declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any policy or certificate issued as a result of this application. I/we understand that this consent may be revoked at any time and that if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid. Suicide within two years of the effective date is a risk not covered under the Term Life plan.
9. I/we understand that subject to the Company's receipt of the properly completed application form (including my/our properly completed Health Declaration), and the first premium payment, coverage will take effect on the first of the month following approval of the Company's underwriters. I/We understand that any health information must be accurate as at the date the application is signed. If you are approved, you will receive a certificate specifying the coverage provided and outlining the main policy provisions. If you are not insurable, a full refund of the premiums will be made.

Signed in the City of _____, and Province of _____.

Signature of Applicant _____ Date _____ (dd/mm/yy)

Signature of Spouse _____ Date _____ (dd/mm/yy)
(if applying)

Signature of Dependent Child _____ Date _____ (dd/mm/yy)
(if over 18)

Signature of Agent/Witness _____ Date _____ (dd/mm/yy)

Signature of Owner _____ Date _____ (dd/mm/yy)
(if different than Applicant)

DETACH AND RETAIN

NOTICE ON EXCHANGE OF INFORMATION. All information requested will be for insurance purposes only and will be treated as confidential. The insurer or its reinsurers may, however, make a brief report on it to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, the bureau will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, the bureau will arrange for disclosure to you of any information it may have in your file on you, your spouse or your children being insured under this plan. If you question the accuracy of the bureau's file, you may contact the bureau and seek a correction. The address of the bureau's information office is: 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

NOTICE ON PRIVACY AND CONFIDENTIALITY. The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, PO BOX 4213 STN A, TORONTO ON M5W 5M3.