Manulife Financial

APPLICATION FOR CHANGE TO ENROLL ADDITIONAL FAMILY MEMBERS TO AN UNDERWRITTEN PLAN

AFFINITY MARKETS NEW BUSINESS AND UNDERWRITING

BASED ON EACH INDIVIDUAL'S MEDICAL HISTORY, COVERAGE MAY BE DECLINED OR MODIFIED TO EXCLUDE CERTAIN CONDITIONS OR BE GIVEN A HIGHER PREMIUM. THE APPLICANT AND CO-APPLICANT MUST COMPLETE AND SIGN THE APPLICANT'S DECLARATION SECTION.

PART A – GENERAL INFORMATION

Plan Number:	ID Number:	
Policy Holder's Last Name:	First Name:	Initial:

Please update if any of the following information has changed:

Apt. Number:	Street Number & Name:	Home Telephone:
City or Town:	Province:	Postal Code:

Policy Holder's Business Phone:	Fax:	E-Mail:
Co-Applicant's Business Phone:	Fax:	E-Mail:

REASON FOR REQUEST: ☐ ADDING CO-APPLICANT ☐ ADDING DEPENDANT CHILD/CHILDREN

PLEASE COMPLETE INFORMATION BELOW FOR FAMILY MEMBERS TO BE ADDED TO YOUR POLICY

NOTE: A CO-APPLICANT WHO IS ADDED TO THE POLICY WILL BECOME THE CO-POLICY HOLDER OF THE PLAN.

PREMIUMS WIL BE REQUIRED AND PROCESSED UPON APPROVAL BASED ON CURRENT BILLING INFORMATION.

PART B – INDIVIDUALS TO BE COVERED

NAME	HEALTH CARD NO.	SEX	DATE OF BIRTH (dd/mm/yyyy)	SMOKER? (Y OR N)*	HEIGHT (cm / inches)	WEIGHT (lbs. / kg.)	WEIGH CHANGE IN THE LAST 12 MONTHS AND REASON
Co-Applicant					❑ cm. ❑ inches	❑ kg. ❑ lbs.	❑ Gain ❑ Loss
Dependant					❑ cm. ❑ inches	❑ kg. ❑ lbs.	❑ Gain ❑ Loss
Dependant					❑ cm. ❑ inches	❑ kg. ❑ lbs.	❑ Gain ❑ Loss

**If smoker number of cigarettes used daily.*

SECTION A – HEALTH CARE PROVIDER

Name and Address of Present Primary Health Care Provider/Physician (who holds the majority of your medical records) and any other Qualified Health Care Practitioners Consulted **(If None Print "None")**

Primary Health Care Provider	**For Co-Applicant**	**For Dependant # 1**	**For Dependant # 2**
Name of Primary Health Care Provider			
Address of Primary Health Care Provider			
Date of last consultation			
Reason for last consultation			
Diagnosis made			
Treatment given			

Name and address of any other Qualified Health Care Practitioners Consulted: _____

Date and reason for consultation: _____

To which individual applying for coverage does this apply? _____

IF YOU REQUIRE ADDITIONAL SPACE TO COMPLETE ANY PART OF THIS QUESTIONNAIRE, PLEASE ATTACH A SEPARATE SHEET.

SECTION B – MEDICAL DECLARATION

1. Has the co-applicant or any listed dependant ever consulted a Physician or other Qualified Health Care Practitioner about, been treated for, or had any known indication of: (**indicate ✓ yes or no to all questions**)

a)	High Blood Pressure, High Cholesterol or any Circulatory or Blood Disorder	❑Yes ❑No	h)	Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV)	❑Yes ❑No
b)	Heart or Blood Vessel Disorder, Heart Murmur, Chest Pain, Angina, Stroke or Transient Ischemic Attack (TIA)	❑Yes ❑No	i)	Arthritis, Rheumatism or Rheumatoid Arthritis	❑Yes ❑No
			j)	Cancer, Tumor, Cyst, Polyp or any Growth	❑Yes ❑No
c)	Back, Neck, Disc, Hip, Knee or Joint Pain or Disorder, Fibromyalgia, Osteoporosis, Osteopenia, Chronic Pain, Paralysis, Weakness or Numbness, or any other Musculoskeletal Pain or Disorder	❑Yes ❑No	k)	Skin Disorder	❑Yes ❑No
			l)	Breast Disorder, Menopause, Reproductive Disorder, Infertility or Assisted Conception	❑Yes ❑No
d)	Digestive System Disorder, Crohn's Disease, Ulcerative Colitis, Liver Disease or Disorder including Hepatitis or Hepatitis Carrier State	❑Yes ❑No	m)	Bladder, Kidney Disorder or Prostate Disorder or other Genitourinary Disorder	❑Yes ❑No
			n)	Headaches or Migraines	❑Yes ❑No
e)	Mental, Nervous, Emotional or Neurological Disorder including Depression, Anxiety, Attention Deficit Disorder or Stress	❑Yes ❑No	o)	Diabetes, Endocrine Disorder, Pituitary or Thyroid Disorder or Lupus	❑Yes ❑No
f)	Alcohol or Drug Abuse, or any addiction	❑Yes ❑No	p)	Eye or Ear Disorder	❑Yes ❑No
g)	Allergies, Asthma, Bronchitis, Respiratory Disorder, Shortness of Breath or Sleep Apnea	❑Yes ❑No	q)	Any other Complaint, Condition, Disease or Disorder Please Specify: _____	❑Yes ❑No

2. Has the co-applicant or any listed dependant ever been treated for, hospitalized or had any known Physical Impairments, Congenital Abnormality, Medical Condition, Disease or Disorder **not** stated above? ❑Yes ❑No

3. Has the co-applicant or any listed dependant ever been advised to have an investigation, hospitalization or surgery which has **not** been completed? ❑Yes ❑No

4. Has the co-applicant or any listed dependant been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years? ❑Yes ❑No

5. If answer is "yes" to questions 1 to 4 of Section B, please give explanation below:

Question No.	Name of individual	Illness, Condition or Diagnosis	Date Diagnosed	Duration	Name & address of Qualified Health Care Practitioner or hospital providing treatment	Current status of condition

6. Is the co-applicant or any listed dependant currently using or expect to use in the next 3 months, or has discontinued use in the last 3 months of any drug, medication or other treatment? ❑Yes ❑No If yes, provide details below:

Name of Individual	Name of drug/medication/serum/treatment	Condition being treated	Strength & daily dosage of drug/medication/serum	Length of time on drug/medication/serum/treatment

7. Is the co-applicant or any listed dependant pregnant? ☐ Yes ☐ No If yes, name and due date: _____

Applicant's Declaration

The Applicant and Co-Applicant, if any, Must Complete This Section. This plan is underwritten by The Manufacturers Life Insurance Company

I/We hereby acknowledge that the statements contained herein are true and complete and together with any other forms signed by me/us in connection with the application form the basis for any policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife Financial or its reinsurers for the purpose of the application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial to consult the application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of the application may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife Financial reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of the application. I/We acknowledge receipt of and agree with Notice on Privacy and Confidentiality previously provided with the application, additional copies of which can be obtained from The Manufacturers Life Insurance Company, upon request. I/We understand and agree that the coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

_____ _____ _____

Signature of Applicant *Signature of Co-Applicant* *Dated (dd/mm/yyyy)*