Flexcare® Application
***All applicants must complete parts A, B, C and D**
***All applicants must complete and sign the Applicant's Declaration**

FlexCare®

Advisor ID: 03235

WSF

Advisor Name:

Advisor Email:

make it count™

AIR MILES®† Collector # | 8 | | | | | | | | | | |

PART A • GENERAL INFORMATION

Applicant's Last Name _____ First Name _____ Initial _____ Health Card Number | | | | | | | | | | | | |

Apt. Number _____ Street Number and Name _____ Home Telephone ( ) _____

City or Town _____ Province _____ Postal Code _____ Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Other Co-Applicant's Last Name _____ First Name _____

Applicant's Office Telephone ( ) _____ Co-Applicant's Office Telephone ( ) _____

Applicant's Email _____ Co-Applicant's Email _____

If additional information is required during regular business hours, how may we contact you? ☐ Home Tel. ☐ Office Tel. ☐ Email

Are you now covered or did you recently have employer group health insurance coverage? ☐ Yes ☐ No

If "Yes", please indicate:

Group Plan Number _____ ID Number _____

Insurance Company _____ Date benefits ended (dd/mm/yyyy) _____

Group Plan Number _____ ID Number _____

Insurance Company _____ Date benefits ended (dd/mm/yyyy) _____

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

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

Applicant's Beneficiary

Name _____

Relationship to Applicant _____

Signature of Applicant _____

Dated (dd/mm/yyyy) _____

Co-Applicant's Beneficiary

Name _____

Relationship to Co-Applicant _____

Signature of Co-Applicant _____

Dated (dd/mm/yyyy) _____

If you designate a beneficiary under the age of 18, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed.

Name of Trustee _____

Relationship to Applicant _____

Signature of Applicant _____

Dated (dd/mm/yyyy) _____

Name of Trustee _____

Relationship to Co-Applicant _____

Signature of Co-Applicant _____

Dated (dd/mm/yyyy) _____

Manulife Financial

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PART B • PLAN CHOICE

Remember: Your Plan Choice applies to all family members.

I/We apply for:

CORE PLANS

- ☐ DrugPlus™ *Basic*
- ☐ DrugPlus *Enhanced*
- ☐ DentalPlus™ *Basic**
- ☐ DentalPlus *Enhanced**
- ☐ ComboPlus™ *Starter**
- ☐ ComboPlus *Basic*
- ☐ ComboPlus *Enhanced*

ADD-ONS

Available only with a Core plan

- ☐ Travel *+8 days**
- ☐ Travel *+21 days**
- ☐ Accidental Death & Dismemberment *Enhanced**
- ☐ Extended Health Care (EHC) *Enhanced*
- ☐ Hospital *Basic*
- ☐ Hospital *Enhanced*
- ☐ Catastrophic Coverage ($4,500 deductible)
- ☐ Catastrophic Coverage ($10,200 deductible)
- ☐ Vision *Enhanced** (Not available with ComboPlus *Starter*)

STAND-ALONES

Available without a Core plan

- ☐ Hospital *Basic*
- ☐ Hospital *Enhanced*
- ☐ Catastrophic Coverage ($4,500 deductible)
- ☐ Catastrophic Coverage ($10,200 deductible)

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

PART C • INDIVIDUALS TO BE COVERED

LAST NAME / FIRST NAME	HEALTH CARD NO.	CODE	SEX	BIRTH DATE DD MM YYYY	AGE	SMOKER? NO. OF CIGARETTES DAILY	HEIGHT inch / cm	WEIGHT lbs / kg	WEIGHT CHANGE IN LAST YEAR GAIN LOSS	REASON FOR WEIGHT CHANGE
APPLICANT		00								
CO-APPLICANT		01								
DEPENDANT		02								
DEPENDANT		02								
DEPENDANT		02								
DEPENDANT		02								

If you require more space to complete any part of this application, please attach a separate sheet.

PART D • PAYMENT OPTIONS

Initial Payment I/We hereby authorize Manulife Financial to debit the initial two (2) months' premium, $_____ using my/our:

Option #1 ☐ Pre-Authorized Debit (PAD)
Option #2 ☐ Credit Card Account

Subsequent Payments Will be made by:

Option #1 ☐ Pre-Authorized Debit (PAD)
PAD Billing Frequency: ☐ Monthly ☐ Semi-Annually (2% discount) ☐ Annually (4% discount)
Important: for verification purposes, we require a sample cheque marked 'VOID'. Please complete Part E.

Option #2 ☐ Credit Card Account
Credit Card Billing Frequency: ☐ Monthly ☐ Semi-Annually ☐ Annually
Please note: billing frequency discounts are not available for credit card payment options.
Please complete Part E.

Option #3 ☐ Direct Billing
Direct Billing Frequency: ☐ Semi-Annually (2% discount) ☐ Annually (4% discount)

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PART E • PAYMENT INFORMATION AND AUTHORIZATION

Credit Card Option Payment Information & Payment Authorization

I/We hereby authorize Manulife Financial to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This Authorization may be terminated by either Manulife Financial or by me/us through written notice. Manulife Financial may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Card Number _____ Expiry Date (mm/yyyy) _____

Name of Cardholder_____ Signature of Cardholder _____

Second Signature if Joint Account _____ Dated (dd/mm/yyyy) _____

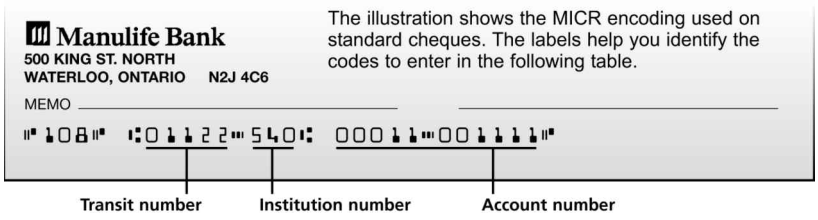
Pre-Authorized Debit (PAD) Payment Information & Payment Authorization

Please use the following banking information:

☐ From the cheque used to make the first payment

OR

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



Transit Number _____ Institution Number _____ Bank Account Number _____

Financial Institution _____ Address _____

Joint Accounts: Is this a joint account requiring only one signature? ☐ Yes ☐ No
If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

I/We authorize Manulife Financial to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife Financial may attempt to withdraw that payment again within 30 days. Manulife Financial reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We or Manulife Financial may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife Financial receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-268-3763, or more_info@manulife.com or write to us at Manulife Financial, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Signature of Cardholder _____ Dated (dd/mm/yyyy)_____

Second Signature if Joint Account _____ Dated (dd/mm/yyyy)_____

Account Holder Address (if different from Applicant)_____

Flexcare Medical Questionnaire

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence no earlier than the first of the month following final approval of this application.

***All applicants must complete and sign the Applicant's Declaration**

SECTION A • TREATING QUALIFIED HEALTH CARE PRACTITIONER

Must be completed in full for all plans except DentalPlus and ComboPlus Starter.

Name and Address of Present Physician or Qualified Health Care Practitioner (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 Applicant	For Co-Applicant	For Dependant(s)
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 Practitioner consulted:_____

_____

Date and Reason for Consultation: _____

To which individual applying for coverage does this apply? _____

If you require more space to complete any part of this application, please attach a separate sheet.

SECTION B • SIMPLIFIED UNDERWRITING QUESTIONNAIRE

Must be completed in full for all plans except DentalPlus and ComboPlus Starter.

Additional medical information may be required to underwrite your application.

Have you, your co-applicant or any listed dependant:

1. Been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years? ☐ Yes ☐ No
2. Consulted or been advised to consult a Qualified Health Care Practitioner about or had any known indication of a medical condition within the last year? ☐ Yes ☐ No
3. Sustained any injury or been treated for any medical condition that requires or has required the services of a Qualified Health Care Practitioner at least once per year within the last 2 years? ☐ Yes ☐ No
4. a) Been advised to use a medication or treatment for a chronic and/or recurring medical condition; ☐ Yes ☐ No
   b) Used any medication or treatment for 20 or more days within the past year; ☐ Yes ☐ No
   c) Expect to use any medication or treatment within the next 3 months. ☐ Yes ☐ No

   Note: Medications used for birth control or to treat minor ailments like cold or flu are not to be considered "Yes" when answering this question.
5. Been diagnosed with any medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization? (Do not include any minor ailments such as the cold or flu.) ☐ Yes ☐ No

If any questions above are answered "Yes", please complete section C below.
If applying for Catastrophic Coverage, please complete sections C and D below.

SECTION C • MEDICAL DECLARATION

Must be completed in full for all plans except DentalPlus and ComboPlus Starter.

Additional medical information may be required to underwrite your application.

1. Have you, your co-applicant or any listed dependant ever consulted a Physician or Qualified Health Care Practitioner about, been treated for or had any known indication of: (✓ "Yes" or "No" to all questions)

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

Continued on Page 5

Flexcare Medical Questionnaire

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence no earlier than the first of the month following final approval of this application.

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SECTION C • MEDICAL DECLARATION (CONTINUED)

2. Have you, your 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 in question number 1**?
   Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant ☐ Yes ☐ No
3. Have you, your co-applicant or any listed dependant ever been advised to have an investigation, hospitalization or surgery which has **not been completed**? Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant ☐ Yes ☐ No
4. Have you, your 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? Applicant ☐ Yes ☐ No Co-Applicant ☐ Yes ☐ No Dependant ☐ Yes ☐ No
5. If answer is "Yes" to questions 1 to 4 of Section C, please give explanation below:

Question No.	Name of Individual	Illness/Condition/Diagnosis	Date Diagnosed	Duration	Name and Address of Qualified Health Care Practitioner and/or Hospital Providing Treatment	Current Status of Condition

6. Are you, your co-applicant or any listed dependant currently using or expect to use in the next 3 months, or have you discontinued use in the last 3 months of any drug, medication, serum or other treatment? ☐ Yes ☐ No If "Yes", provide details below:

Name of Individual	Name of the Drug/Medication/Serum/Treatment	Condition Being Treated	Strength and Daily Dosage of the Drug/Medication/Serum	Monthly Cost	Length of Time on This Drug/ Medication/Serum/Treatment

7. Are you, your co-applicant or any listed dependant pregnant? ☐ Yes ☐ No

   If "Yes", Name of pregnant individual _____ Due Date (dd/mm/yyyy)_____

SECTION D • CATASTROPHIC MEDICAL QUESTIONNAIRE

Must also complete Sections A, B and C when applying for Catastrophic Coverage

(Available either as an Add-On or Stand-Alone coverage)

1. Have you, your co-applicant or any listed dependant, natural parents, brother(s) or sister(s), either living or dead, ever suffered from any of the following conditions: Heart Disease, Stroke, Cancer (specify type), Diabetes, Kidney Disease, Mental Illness, Alcoholism, Huntington's Chorea, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's or any other hereditary disease? If "Yes", please complete the section below. ☐ Yes ☐ No

Name of Individual	Relationship to Proposed Insured	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death

2. Have you, your co-applicant or any listed dependant participated in the last 3 years or expect to participate in, any activities of a hazardous nature including, but not limited to: Motorized Vehicle Racing, Skin or Scuba Diving, Sky Diving, Mountain Climbing, Hang-Gliding, or any other hazardous sports or activities? ☐ Yes ☐ No

   If "Yes", please indicate the name of the avocation(s)/sport(s) and person(s) to whom it applies:

   _____

3. Do you, your co-applicant or any listed dependant, intend to fly other than as a passenger on a commercial airline, or have flown other than as a passenger on a commercial airline within the past 3 years? ☐ Yes ☐ No

   If "Yes", please indicate the name of the person(s) to whom this applies:_____

4. Have you, your co-applicant or any listed dependant in the last 3 years had your driver's licence suspended, revoked or had 3 or more moving violations? ☐ Yes ☐ No

   If "Yes", please provide the name of the person(s) to whom this applies: _____

   Driver's Licence Number(s) _____

If any questions above are answered "Yes", a supplemental questionnaire will be sent to you for completion.
If you require more space to complete any part of this application, please attach a separate sheet.

ADVISOR'S REPORT

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

YOUR NAME (FIRST, MIDDLE INITIAL, LAST)	ADVISOR CODE	SIGNATURE
		✖

Please send the completed application to:

For Regular Mail:
Manulife Financial
P.O. Box 670
Stn Waterloo
Waterloo, ON N2J 4B8

For Courier:
Manulife Financial
500 King Street
Affinity Markets New Business
Delivery Station 500-GB
Waterloo, ON N2J 4C6

Note: If you are contracted through a MGA/National Account firm, please forward the completed application to their office.

APPLICANT'S DECLARATION • ALL APPLICANTS MUST COMPLETE THIS SECTION

This Plan is underwritten by The Manufacturers Life Insurance Company.

☐ Check here if you do not wish to receive further information and material on Manulife Financial's products.

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

Signature of Applicant _____ Dated (dd/mm/yyyy) _____

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

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. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to:

Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Station A, Toronto, Ontario M5W 5M3.

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

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