Manulife Financial

Evidence of Insurability for Optional Life Insurance

INSTRUCTIONS
Please print all answers

1. ***Please check (✓) the appropriate box(es) for type of evidence.***
   ◯ *Plan member - Parts 1, 2, 4 and 5.* ◯ *Dependent - Parts 2, 3, 4 and 5.*

2. ***Please ensure that all applicable Parts are completed.***
   Part 1 - Plan sponsor statement
   Part 2 - Plan member statement
   Part 3 - Dependent statement
   Part 4 - Medical questionnaire
   Part 5 - Certification and authorization

1 Plan sponsor statement

Plan number(s)	Account number/Division	Certificate number
		Plan sponsor/Employer

2 Plan member statement

Plan member's name (last, first and middle initial)

Sex	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
◯ Male ◯ Female		( )	( )

Plan member's address (street number, street, apartment)

City	Province	Postal code
		—

Height	Weight	Have you or your spouse, smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months?
_____ m _____ cm _____ ft _____ in	◯ kg ◯ lb	**Plan member** ◯ Yes ◯ No **Spouse** ◯ Yes ◯ No

Name of personal physician (last, first and middle initial) **(For plan member and dependents)**

Address of personal physician (suite/street number, street, apartment)

City	Province	Postal code
		—

3 Dependent statement

To be completed when dependents are applying for coverage.

Please provide the following information for each dependent to be insured.

COMPLETE NAME OF ELIGIBLE DEPENDENT	SEX	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (dd/mmm/yyyy)	HEIGHT ◯ m ◯ cm ◯ ft ◯ in	WEIGHT ◯ kg ◯ lbs
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				

(Please complete page 2 of this form.)

If required, retain a photocopy for your files.

4 Medical questionnaire

	Plan member	Spouse	Children
1. Have you, within the last three (3) years, had an application for life or health insurance declined, postponed or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you, within the last three (3) years, consulted a physician, or been treated, for high blood pressure, chest pain, heart attack, heart murmur, stroke, cancer, tumour, ulcer, colitis, diabetes, asthma, epilepsy, back pain, mental, nervous illness, emotional condition, anxiety or depression, urinary tract infection, sexually transmitted disease, alcoholism, drug addiction, or any disease or disorder of the heart, blood, lungs, liver, kidneys, or urine?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Have you, within the last three (3) years, been told that you had any immune deficiency disorder, including AIDS or AIDS RELATED COMPLEX (ARC), or any generalized enlargement of your lymph glands, or any test results indicating possible exposure to the AIDS virus (e.g. HIV, HTLV-III, LAV)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you had surgery or been hospitalized within the past three years?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
5. Have you consulted a physician or other practitioner within the past sixty days and been advised to have further treatment, examination, diagnostic test, or surgery not already performed?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
6. Have you, during the last five (5) years had X-rays, Electrocardiograms, blood or other special tests, for other than regular medical checkups?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
7. Any family history of any inherited or familial disease? (e.g. Huntington's Chorea, diabetes, heart or kidney disease)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
8. Have you or your dependents: (a) flown as a pilot, student pilot or crew member during the last 3 years or have any intention of doing so? (b) ever engaged in racing, underwater diving, parachuting or any other hazardous sport or is any such activity contemplated? Please specify which activity. _____	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ Yes ◯ No

Please provide details below, if you have answered "Yes" to *ANY* questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

QUESTION NUMBER	NAME OF PERSON (FIRST & MIDDLE)	DETAILS OR NAME OF CONDITION	DATE AND DURATION	TREATMENT AND RESULTS (RECOVERY OR REMAINING EFFECTS)	NAMES AND ADDRESSES OF DOCTORS AND HOSPITALS

5 Certification and authorization

I certify that the information in this form is true and complete, to the best of my knowledge.
I authorize any health care provider, other insurance company, workers' compensation board, my employer, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process my application for insurance.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.
I agree that a photocopy of this authorization shall be as valid as the original.

Signature of plan member	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date signed (dd/mmm/yyyy)

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:
• our employees and representatives in the performance of their jobs;
• persons to whom you have granted access; and
• persons authorized by law.
You have the right to request access to the personal information in your file, and, if necessary, correct any inaccurate information.