Manulife

The Manufacturers Life Insurance Company

Application for Professional Pool - Term Life Group Insurance

Section 1: Applicant Information

Member of (Professional Association Name):

Last Name First Name Initial ☐ Male ☐ Female

Home Address Unit/Apt. City Province Postal Code

Date of Birth DD/MM/YYYY Place of Birth (province, country) ☐ Smoker ☐ Non-Smoker*

Preferred Contact Number Email

Occupation

Are you self-employed? ☐ Yes ☐ No If yes, please describe the nature of your business/duties:

Spouse Information (if applying for Spouse coverage)

Spouse's Last Name First Name ☐ Male ☐ Female

Spouse's Date of Birth DD/MM/YYYY Place of Birth (province, country) ☐ Smoker ☐ Non-Smoker*

Spouse's Occupation (If self-employed, please describe nature of business/duties):

Preferred Contact Number:

*Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products, including e-cigarettes, in the past 12 months.

Section 2: Amount of Insurance Applying for

I am applying for: ☐ New coverage ☐ Additional coverage If currently insured under this plan, your policy number:

Term Life Insurance (Do not include coverage already in force. Maximum coverage is $750,000.)

10% volume savings on $200,000 or more.

Applicant Please indicate amount you're applying for in increments of $25,000: Available from $50,000 to $750,000. $ ____

Spouse Please indicate amount you're applying for in increments of $25,000: Available from $50,000 to $750,000. $ ____

Personal Accident Insurance (Available from $50,000 to $250,000 in increments of $25,000. Please indicate amount you are applying for.)

Applicant: Available if you participate in the Term Life Plan (check one box only).

Amount of Coverage	Up to $100,000	Up to $150,000	Up to $200,000	Up to $250,000	Other amount
Your Monthly Premium	☐ $6.00	☐ $9.00	☐ $12.00	☐ $15.00	☐ $

Spouse: Available if you participate in the Spouse Term Life Plan (check one box only).

Amount of Coverage	Up to $100,000	Up to $150,000	Up to $200,000	Up to $250,000	Other amount
Your Monthly Premium	☐ $6.00	☐ $9.00	☐ $12.00	☐ $15.00	☐ $

Child Life & Accident Insurance

One monthly premium of $2.25 covers all of your eligible children for $10,000 of life coverage each. ☐ Yes

Applicant: Existing Coverage

Do you have any pending or existing life insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Insurance Company Name	Personal or Business	Coverage Amount	Do you intend to replace this coverage?
	☐ Personal ☐ Business	$	☐ Yes ☐ No
	☐ Personal ☐ Business	$	☐ Yes ☐ No
	☐ Personal ☐ Business	$	☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Spouse: Existing Coverage

Do you have any pending or existing life insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Insurance Company Name	Personal or Business	Coverage Amount	Do you intend to replace this coverage?
	☐ Personal ☐ Business	$	☐ Yes ☐ No
	☐ Personal ☐ Business	$	☐ Yes ☐ No
	☐ Personal ☐ Business	$	☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Section 3: Beneficiary Information (Term Life & Accidental Death Coverage)

Applicant Beneficiary(ies):

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

1. Last Name First Name

   Relationship to you, the applicant % of Benefit

2. Last Name First Name

   Relationship to you, the applicant % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

1. Last Name First Name

   Relationship to the beneficiary % of Benefit

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Section 3: Beneficiary Information (Term Life & Accidental Death Coverage) (continued)

Spouse Beneficiary(ies):

In accordance with the Group Policy, the Applicant is automatically the beneficiary on any Spouse Term Life or Accidental Death Coverage, unless the Applicant designates a beneficiary to receive the proceeds. Only the Applicant has the right to designate a beneficiary and may do so below if he/she wishes to.

I (the Applicant) hereby designate the individual(s) named below to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Applicant.

1. Last Name First Name

   Relationship to applicant % of Benefit

2. Last Name First Name

   Relationship to applicant % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

1. Last Name First Name

   Relationship to the beneficiary % of Benefit

For Quebec residents only:

In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Note: The beneficiary designations above relate only to any additional coverage being purchased. Beneficiary designation for coverage already issued will remain in force as is. A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Section 4: Financial Information

Applicant: What is your annual net earned income, after expenses but before taxes? $

Spouse: What is your annual net earned income, after expenses but before taxes? $

Applicant and Spouse: What is your combined net worth (assets minus liabilities)? $

Section 5: Your Personal Information

Please ensure all questions are answered and details provided for all individuals applying for coverage. If you require additional space, please use a separate page, signed and dated.

Have you:	Applicant YES	Applicant NO	Spouse YES	Spouse NO
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:	☐	☐	☐	☐
2. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked:	☐	☐	☐	☐
b) Within the past 2 years, been charged with or convicted of 2 or more moving or traffic violations (for example, speeding, failure to stop, seat belt violations, distracted driving or failure to provide a breathalyzer sample)? If yes, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province:	☐	☐	☐	☐
3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s):	☐	☐	☐	☐

Section 5: Your Personal Information (continued)

	Applicant YES	Applicant NO	Spouse YES	Spouse NO
4. Within the next 12 months: a) Any expectation to travel outside Canada and the United States of America? If yes, give details including where, when, why and for how long:	☐	☐	☐	☐
b) Any expectation to change your country of residence? If yes, provide details, including where you intend to move, when you are moving, why you are moving and if your occupation is changing:	☐	☐	☐	☐
5. Within the past 5 years: a) Used any drugs other than for medical purposes; used marijuana; or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug(s) used, alcohol type(s), daily consumption and date(s) last used:	☐	☐	☐	☐
b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details:	☐	☐	☐	☐
c) Declared, or are you currently contemplating personal or business bankruptcy? If yes, provide details including date of discharge:	☐	☐	☐	☐

Section 6: Health Declaration

Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.

Applicant's Name

Applicant's Phone Number

Physician's Name

Physician's Phone Number

Physician's Address

Date and reason of last consultation:

Result of last consultation, and any treatment or medication prescribed:

Height (include ft & in or cm):

Weight (include lb or kg):

Has your weight changed by more than 10 lbs (4.5 kg) in the past 12 months? ☐ Yes ☐ No

If yes: ☐ Gained (include lb or kg):

☐ Lost (include lb or kg):

Reason for change:

If applying for Spouse

Physician's Name

Physician's Phone

Date and reason of last consultation:

Result of last consultation, and any treatment or medication prescribed:

Height (include ft & in or cm):

Weight (include lb or kg):

Has your weight changed by more than 10 lbs (4.5 kg) in the past 12 months? ☐ Yes ☐ No

If yes: ☐ Gained (include lb or kg):

☐ Lost (include lb or kg):

Reason for change:

Section 7: Your Medical Information

IMPORTANT: Any reference to testing, tests, test results or investigations in this section 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.

1. Have you ever had any indication of or been treated for conditions involving any of the following:	Applicant YES	Applicant NO	Spouse YES	Spouse NO
a) **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐	☐	☐	☐
b) **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐	☐	☐	☐
c) **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐	☐	☐	☐
d) **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐	☐	☐	☐
e) **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐	☐	☐	☐
f) **Your brain or nervous system** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐	☐	☐	☐
g) **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐	☐	☐	☐
h) **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐	☐	☐	☐
i) **Your blood or glands**, such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐	☐	☐	☐
j) **Your muscles, bones or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints or spine causing any physical limitations or restrictions, or other?	☐	☐	☐	☐
k) **Your skin,** such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size or colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐	☐	☐	☐
l) **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐	☐	☐	☐
m) **Cancer**, cysts, lumps, polyps, or tumour?	☐	☐	☐	☐
n) **Other illness or disorder** not mentioned above, or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐	☐	☐	☐
2. If female, a) are you currently pregnant? If yes, give your due date and the name and address of your obstetrician/gynecologist:	☐	☐	☐	☐
b) What was your pre-pregnancy weight? lb/kg				
c) Have there been any complications with your pregnancy? If yes, provide details:	☐	☐	☐	☐
3. Within the past 2 years, have you:				
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐	☐	☐
b) Consulted a specialist or been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	☐	☐	☐	☐
c) Been advised to undergo further investigation, see another doctor or have surgery?	☐	☐	☐	☐
d) Been currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐	☐	☐

If you answered yes to any part of questions 1, 2 and 3 above, please give details below:

Question No.	Name of Applicant	Nature of Disorder	Date & Duration	Treatment & Current Status (If none, state "None")	Attending Physician or Hospital

Family Medical History

	Applicant YES	Applicant NO	Spouse YES	Spouse NO
4. Have any of your parents or siblings (brothers or sisters):				
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐	☐	☐
b) Ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), 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 or retinitis pigmentosa?	☐	☐	☐	☐

If you answered yes to a) or b) above, please complete the following:

Name of Applicant	Family Member	Condition (If cancer, specify type)	Age at Onset	Age at Death & Cause, if applicable

Children's Insurance (Complete if applying for insurance for your children)

If child's address is different from Applicant's, please provide:

Name and address of **each** child's physician

Date of last consultation DD/MM/YYYY Reason for last consultation

Treatment, medication prescribed (if none, state "None")

In the past year, has any child lost more than 5 pounds (2.25 kg)? ☐ Yes ☐ No

If yes, provide **name of child and reason** for weight loss:

Name of Child First	Last	Gender	Date of Birth	Height (include ft.& in. or cm.)	Weight (include lbs. or kg.)
		☐M ☐F	DD/MM/YYYY		
		☐M ☐F	DD/MM/YYYY		
		☐M ☐F	DD/MM/YYYY		
		☐M ☐F	DD/MM/YYYY		

For Quebec residents only:

If you are mailing your Health Declaration to Manulife separately, please complete the following:

Applicant's Last Name First Name Initial Telephone

Section 8: Payment Information

☐ **Monthly by pre-authorized debit** – PAD (please enclose a sample cheque marked "VOID")
Please complete Section A below.

☐ **Annually by cheque** (payable to Manulife)

$		X		+		= $	
	Total monthly premium		No. of months to March 1 (excluding present month)		Provincial sales tax if applicable		**AMOUNT PAYABLE TO NEXT MARCH 1**
					0.00%		0.00

Payment Information

Section A: For pre-authorized debit (PAD) payment option

Name of Account Holder Financial Institution

Address City/Town

Bank Account Number Transit Number

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ Current ☐ Direct Deposit Account ☐ Other

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.

Payment authorization for pre-authorized debit (PAD) payment options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account on the day on which insurance premiums are due or after 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 10 days 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 may attempt to withdraw that payment again within 30 days. Manulife 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 Payments Canada in Rule H-1. I/We or Manulife 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 receives another form of payment.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-668-0195 or am_service@manulife.com, or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, ON 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.payments.ca.

Name of Account Holder Signature of Account Holder _____

Second signature if joint account_____ Dated DD/MM/YYYY

Account holder address (if different than applicant)

To apply securely using your credit card, contact our licensed insurance advisors at **1 800 668-0195**.

For your convenience, if you choose payment by pre-authorized debit or credit card, your future premium billings will automatically reflect the same payment method.

Information about MIB, LLC

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, LLC 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, LLC is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, LLC will share any information it has on file. You may review the information in your file, and request a correction if necessary, by contacting MIB, LLC at:

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

Personal Information Statement

At Manulife protecting your personal information and respecting your privacy is important to us.

"We", "us" and "our" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Why do we collect, use, and disclose your personal information?

For the purposes of establishing and managing our relationship with you, providing you with products and services, administering our business, and complying with legal and regulatory requirements.

What personal information do we collect?

Depending on the product or service, 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 your Social Insurance Number (SIN)
- Financial information, investigative reports, credit bureau report, and/or a consumer report
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking and employment information
- Medical information that any organization or person has about you
- Any test that may be necessary for underwriting purposes
- Other personal information that we may require to administer your products or services and manage our relationship with you

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

Where do we collect your personal information from?

Depending on the product or service, we collect personal information from:

- Your completed applications and forms
- Other interactions between you and us
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal with in issuing and administering your products or services now, and in the future
  - Public sources, such as government agencies, credit bureaus and internet sites
  - Financial institutions
  - Your employer or Plan Sponsor and their authorized agents, consultants and plan service providers
  - The MIB, LLC (formerly known as the Medical Information Bureau)
  - Health Care Professionals, including Medical Practitioners, health care institutions, pharmacy and any other medically-related facility

What do we use your personal information for?

Depending on the product or service, we will use your personal information to:

- 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
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us make decisions and understand our customers better so we can improve the products and services we provide
- Perform audits, and investigations and protect you from fraud
- Determine your eligibility for, and provide you with details of, other products and services that may be of interest to you
- Automate processing to help us make decisions about your interactions with us, such as, applications, approvals or declines

Who do we disclose your information to?

Depending on the product or service, we disclose your personal information to:

- Persons, financial institutions, reinsurers, and other parties with whom we deal with in issuing and administering your product or service now, and in the future
- Authorized employees, agents and representatives
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- Your employer or Plan Sponsor and their authorized agents, consultants and plan service providers
- 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 doctor
- Public health authorities as required

Except where there are contractual restrictions, these people, organizations and service providers are both within Canada and outside of Canada. Therefore, your personal information may be subject to interprovincial or cross-border transfers in order to provide services to you and 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.

Withdrawing your consent

You may withdraw your consent for us to use your personal information for certain uses, subject to legal and contractual restrictions.

You may not withdraw your consent for us to collect, use, or disclose personal information we need to issue or administer your products and services. If you do so, we may not be able to provide you with the products or services requested or we may treat your withdrawal of consent as a request to terminate or refusal of the product or service.

If you wish to withdraw your consent, phone our customer care centre at **1-877-268-3763**, or write to the Privacy Officer at the address below.

Accuracy

You will notify us of any change to your contact information. If your information has changed, or if you need to make a correction of any inaccuracies to your personal information in our files, you may contact us at **1-877-268-3763**.

Access

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. Requests can be sent to: **Privacy Officer, Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**.

For more information you can review our **Canadian Privacy Policy**. Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email.

Declaration and Authorization – Please read carefully before signing.

I (the Applicant) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

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. 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. Suicide within the first two years is a risk not covered. 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, MIB, LLC, 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 pursuant to this application to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I/We authorize Manulife to consult its existing files for this purpose. I/We authorize Manulife to obtain a credit report and/or consumer report.

I/We authorize Manulife, 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 at the address shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/We acknowledge receipt of and confirm my/our agreement with the Information about MIB, LLC and Personal Information Statement.

I (the Applicant) hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my or, if applicable, my Spouse's death.

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. 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.

I/We acknowledge that the insurer may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be made at no expense to me/us. I/We further acknowledge that results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law and that, based on my/our health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

I/We acknowledge that coverage will take effect on the date the properly completed application (including my/our properly completed health declaration) and the first premium are received by Manulife, subject to the approval of the Company's underwriters. If I am/we are applying for new coverage and am/are approved, I/we will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am/we are not insurable, a full refund of the premiums will be made.

By providing your email address herein, you consent to us providing information or documents to you in respect of this application or policy, as applicable, in electronic form.

Quebec residents only:

The French version of the application was provided, I wish to complete the English version. As per Quebec law, I will receive the Certificate of Insurance in both English and French and all further related documentation will be sent exclusively in English.

Signature of Applicant _____ Signed at City, Province Date DD/MM/YYYY

Signature of Spouse _____ Signed at City, Province Date DD/MM/YYYY

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, 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

Send your completed application form along with your initial premium payment to
Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

For more information about Term Life Group Insurance or to apply,
visit the website at **manulife.com/professional** today.

If you need assistance, or to speak with a licensed insurance advisor,
call Manulife at **1-800-668-0195,** Monday to Friday from 8 a.m. to 8 p.m. ET.
or email **am_info@manulife.com.**

Manulife

Plan underwritten by **The Manufacturers Life Insurance Company (Manulife).**

Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.
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