

**\*All applicants must complete parts A, B, C and D**

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



*make it count*

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

**WSF**

Advisor ID: 949853
Advisor Name: Glenn Cooke, InsureCan Inc
Advisor Email: glenn@insurecan.com

**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

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):

<b>Applicant's Beneficiary</b>	<b>Co-Applicant's Beneficiary</b>
Name _____	Name _____
Relationship to Applicant _____	Relationship to Co-Applicant _____
Signature of Applicant _____	Signature of Co-Applicant _____
Dated (dd/mm/yyyy) _____	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 _____	Name of Trustee _____
Relationship to Applicant _____	Relationship to Co-Applicant _____
Signature of Applicant _____	Signature of Co-Applicant _____
Dated (dd/mm/yyyy) _____	Dated (dd/mm/yyyy) _____

**PART B • PLAN CHOICE**

Remember: Your Plan Choice applies to all family members, except Lifeline®.

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\* (Not available with ComboPlus Starter)
- Travel +21 days\* (Not available with ComboPlus Starter)
- Accidental Death & Dismemberment Enhanced\*
- Extended Health Care (EHC) Enhanced
- Hospital Basic
- Hospital Enhanced
- Hospital Cash
- Catastrophic Coverage
- Vision Enhanced\* (Not available with ComboPlus Starter)

**STAND-ALONES Available without a Core plan**

- Extended Health Care (EHC) Basic
- Extended Health Care (EHC) Enhanced
- Hospital Basic
- Hospital Enhanced
- Hospital Cash
- Catastrophic Coverage

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

For Lifeline® Personal Response Service, call 1-877-268-3763 and request a Lifeline application.

**PART C • INDIVIDUALS TO BE COVERED**

LAST NAME	FIRST NAME	HEALTH CARD NO.	CODE	SEX	BIRTH DATE	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								

**PART D • PAYMENT OPTIONS**

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

Option #1  Financial Services Account (Pre-Authorized Debit)

Option #2  Credit Card Account

**Subsequent Payments** will be made by:

Option #1  Pre-Authorized Debit (PAD) from my/our Financial Services Account  
 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)

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



**Flexcare Application – Page 2**

**\*All applicants must complete parts A, B, C and D**

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

**PART E • PAYMENT INFORMATION AND AUTHORIZATION**

**Payment Information**

**For Pre-Authorized Debit (PAD) payment options**

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.

**For Credit Card payment options**

Credit Card:  Visa  MasterCard  American Express

Account Number \_\_\_\_\_ Expiry Date (mm/yyyy) \_\_\_\_\_

Name of Cardholder \_\_\_\_\_ Signature of Cardholder \_\_\_\_\_

**Payment Authorization**

**For Pre-Authorized Debit (PAD) payment options**

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 Account Holder \_\_\_\_\_ Dated (dd/mm/yyyy) \_\_\_\_\_

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

Account Holder Address (if different from Applicant) \_\_\_\_\_

**For Credit Card payment options**

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.

Signature of Cardholder \_\_\_\_\_ Dated (dd/mm/yyyy) \_\_\_\_\_

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

**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 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 Applicant	For Co-Applicant	For Dependand(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.**

**Flexcare Medical Questionnaire – Page 3**

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 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 \_\_\_\_\_

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 above**? 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. If answer is "Yes" to questions 1 to 3 of Section C, please give explanation below:

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

5. 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? If "Yes", provide details below:  Yes  No

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

6. 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

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, 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: \_\_\_\_\_

A supplemental questionnaire will be sent to you for completion.

**Continued on Page 4**

**Flexcare Medical Questionnaire – Page 4**

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 D • CATASTROPHIC MEDICAL QUESTIONNAIRE (CONTINUED)**

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: \_\_\_\_\_  
\_\_\_\_\_

A supplemental questionnaire will be sent to you for completion.

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) \_\_\_\_\_

A supplemental questionnaire will be sent to you for completion.

**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 *
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Please send the completed application to:

**For Regular Mail:**  
InsureCan Inc.  
165 Peel Street, #2  
New Hamburg, Ontario  
N3A 1E7

**By Fax: (866) 492-4419**

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. 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.

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