

*All applicants must complete parts A, B, C, D, E

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

WSE



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 Fax () _____ Co-Applicant's Fax () _____

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):

Applicant's Beneficiary

Co-Applicant's Beneficiary

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) _____

Flexcare Application – Page 2

***All applicants must complete parts A, B, C, D, E**

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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			AGE	SMOKER? NO. OF CIGARETTES DAILY	HEIGHT inch / cm	WEIGHT lbs / kg	WEIGHT CHANGE IN LAST YEAR		REASON FOR WEIGHT CHANGE
					DD	MM	YYYY					GAIN	LOSS	
APPLICANT														
CO-APPLICANT														
DEPENDANT														
DEPENDANT														
DEPENDANT														
DEPENDANT														

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.

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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 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 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.

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 1-877-COVER ME® (1-877-268-3763), www.coverme.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.

Name of Account holder _____ Signature of Account holder _____

Second signature if joint account _____ Dated (dd/mm/yyyy) _____

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.

Name of Cardholder _____ Signature of Cardholder _____

Second signature if joint account _____ Dated (dd/mm/yyyy) _____

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

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.

***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 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? _____

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

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

Flexcare Medical Questionnaire – Page 5

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 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. 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 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

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, 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), 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? Yes No

If “Yes”, please complete the section below.

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

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

Flexcare Medical Questionnaire – Page 6

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)

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.

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 drivers license 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: _____

Drivers License Number(s) _____

A supplemental questionnaire will be sent to you for completion.

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) _____

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

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