Manulife Financial

Evidence of Insurability

INSTRUCTIONS

1. ***Please check (✓) the appropriate box(es) for type of evidence.***
   ☐ ***Plan member - Parts 1, 2 and 4.*** ☐ ***Dependent - Parts 1, 3 and 4.***
2. ***Please ensure that all applicable Parts are completed.***
   Part 1 - Plan Sponsor Statement ***Part 3 - Dependent Statement***
   Part 2 - Plan Member Statement ***Part 4 - Declaration and Authorization***

- ***Please print all answers.***

Mail the completed and signed form to:
Manulife Financial
Group Medical Underwriting
PO BOX 1650
WATERLOO ON N2J 4V7

PART 1 - PLAN SPONSOR STATEMENT

PLAN NUMBER	ACCOUNT/DIVISION	CERTIFICATE NUMBER	PLAN SPONSOR
G			

EMPLOYER NAME (if different from Plan Sponsor)

PART 2 - PLAN MEMBER STATEMENT

1. PLAN MEMBER NAME (last name, first name, middle initial)
2. DATE OF BIRTH D M Y
3. SEX ☐ MALE ☐ FEMALE
4. OCCUPATION
5. ADDRESS OF PLAN MEMBER Apt./Street number Street City Province Postal code
6. NAME OF PERSONAL PHYSICIAN (last name, first name, middle initial) Physician's phone no. ( )
7. ADDRESS OF PERSONAL PHYSICIAN Suite/Street number Street City Province Postal code
8. HEIGHT _____ m _____ cm _____ ft _____ in
9. WEIGHT ☐ kg ☐ lb
10. Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No
    Home phone no. ( )
    Business phone no. ( )
11. Have you lost or gained more than 10 lbs. during the last 12 months? ☐ Yes ☐ No If "Yes", please answer the following:
    What was the amount of weight change? _____ ☐ kg ☐ lb Reason:
    Was this a gain ☐ or a loss ☐ ?

PLEASE PROVIDE DETAILS BELOW, IF YOU HAVE ANSWERED "YES" TO QUESTIONS 12, 13 OR 14 INCLUSIVE.

12. Do you currently participate in any hazardous sport activity, such as SCUBA diving, piloting aircraft, auto racing, etc.? ☐ YES ☐ NO
    Please specify which activity _____
13. Have you
    (a) ever applied for or received benefits, compensation or pension because of sickness or injury? ☐ YES ☐ NO
    (b) ever had an application for life or health insurance declined, postponed, or modified in any way? ☐ YES ☐ NO
    (c) been absent from work for medical reasons during the last 5 years? ☐ YES ☐ NO
    (d) are you currently receiving any treatment? ☐ YES ☐ NO
    (e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment? ☐ YES ☐ NO
    (f) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)? ☐ YES ☐ NO
14. Have you ever consulted a physician, ever been treated for, or had any known identification of
    (a) chest pain, blood vessel disease, heart disorder, or heart attack? ☐ YES ☐ NO
    (b) high blood pressure, stroke? ☐ YES ☐ NO
    (c) allergies or skin disorders, including growths, cysts or tumours? ☐ YES ☐ NO
    (d) glandular disorders, including thyroid disorders and diabetes? ☐ YES ☐ NO
    (e) epilepsy, nervous or mental illness, or an emotional condition such as anxiety or depression? ☐ YES ☐ NO
    (f) excessive use of alcohol or drugs? ☐ YES ☐ NO
    (g) lung disorders? ☐ YES ☐ NO
    (h) bowel disorders, stomach or liver disorders? ☐ YES ☐ NO
    (i) cancer? ☐ YES ☐ NO
    (j) disorder of the kidney, urine or genital organs? ☐ YES ☐ NO
    (k) arthritis or rheumatism? ☐ YES ☐ NO
    (l) disorders of the muscles or bones including the back, spine or joints? ☐ YES ☐ NO
    (m) immune deficiency disorder including AIDS or AIDS-related complex (ARC), or any generalized enlargement of the lymph glands, or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus? ☐ YES ☐ NO
    (n) any physical impairments, deformities, amputations or illness not covered above? ☐ YES ☐ NO

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

NOTE: PLEASE REMEMBER THAT PART 4 ON PAGE 2 OF THIS FORM MUST ALWAYS BE SIGNED AND DATED

PART 3 - DEPENDENT STATEMENT *To be completed when dependents are applying for coverage.*

1. COMPLETE NAME OF ELIGIBLE DEPENDENT	SEX	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH D M Y	HEIGHT ☐ m ☐ cm ☐ ft ☐ in	WEIGHT ☐ kg ☐ lbs
	☐ MALE ☐ FEMALE				
	☐ MALE ☐ FEMALE				
	☐ MALE ☐ FEMALE				
	☐ MALE ☐ FEMALE				

2. NAME OF DEPENDENT'S PERSONAL PHYSICIAN (last name, first name, middle initial) | Physician's phone no. ( )

3. ADDRESS OF PERSONAL PHYSICIAN Suite/Street number Street City Province Postal code

4. Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ☐ YES ☐ NO

PLEASE PROVIDE DETAILS BELOW, IF YOU HAVE ANSWERED "YES" TO QUESTIONS 5, 6 or 7 INCLUSIVE.

5. Do any of the dependents who are to be insured currently participate in any hazardous sport activity, such as SCUBA diving, piloting aircraft, auto racing, etc.? Please specify which activity _____ ☐ YES ☐ NO

6. Have any of the eligible dependents
   (a) any condition which might require medical consultation,hospitalization or future surgical or psychiatric treatment? ☐ YES ☐ NO
   (b) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)? ☐ YES ☐ NO
   (c) who are to be insured ever had an application for life or health insurance declined, postponed, or modified in any way? ☐ YES ☐ NO

7. Have any of the eligible dependents ever consulted a physician, ever been treated for, or had any known identification of
   (a) chest pain, blood vessel disease, heart disorder or heart attack? ☐ YES ☐ NO
   (b) high blood pressure, stroke? ☐ YES ☐ NO
   (c) allergies or skin disorders, including growths, cysts or tumours? ☐ YES ☐ NO
   (d) glandular disorders, including thyroid disorders and diabetes? ☐ YES ☐ NO
   (e) epilepsy, nervous or mental illness, or an emotional condition such as anxiety or depression? ☐ YES ☐ NO
   (f) excessive use of alcohol or drugs? ☐ YES ☐ NO
   (g) lung disorders? ☐ YES ☐ NO
   (h) bowel disorders, stomach or liver disorders? ☐ YES ☐ NO
   (i) cancer? ☐ YES ☐ NO
   (j) disorder of the kidney, urine or genital organs? ☐ YES ☐ NO
   (k) arthritis or rheumatism? ☐ YES ☐ NO
   (l) disorders of the muscles or bones including the back, spine or joints? ☐ YES ☐ NO
   (m) immune deficiency disorder including AIDS or AIDS-related complex (ARC), or any generalized enlargement of the lymph glands, or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus? ☐ YES ☐ NO
   (n) any physical impairments, deformities, amputations or illness not covered above? ☐ YES ☐ NO

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

PART 4 - DECLARATION 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, any type of workers' compensation board, my plan sponsor, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process my application for insurance. I agree that a photocopy of this authorization shall be as valid as the original.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.

SIGNATURE OF PLAN MEMBER	DATE SIGNED D M Y
SIGNATURE OF SPOUSE (required only if evidence regarding insurability of spouse is provided in this form)	DATE SIGNED D M Y

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 service 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.