

Applying is Easy!

Members and Spouses must be between 18 and less than 61 years of age. Eligible children are those unmarried, dependent on the member for support and over 14 days of age and under 21 or over 20 but less than 25 years of age if attending school or university full time. All applicants must be residing in Canada.

1. MEMBER INFORMATION

New Client Existing Client

Certificate # (if existing) _____

Name _____
LAST FIRST INITIAL

Address _____
STREET UNIT/ APT.#

CITY/TOWN PROVINCE POSTAL CODE

Telephone (Residence) () _____ (Business) () _____ E-mail _____

I am a member of _____
(Name of Association/Society)

Member's Occupation _____ Spouse's Occupation _____
(if applying for spousal coverage)

2. PERSON(S) TO BE INSURED List all family members to be covered. If you need more space, please use a separate sheet.

FIRST NAME	LAST NAME	SEX	BIRTH DATE			COUNTRY OF BIRTH	IF SMOKER, # of cigarettes smoked daily	HEIGHT	WEIGHT	WEIGHT CHANGE IN LAST YEAR		REASON*
			DD	MM	YYYY					Gain	Loss	
MEMBER												
SPOUSE												
DEPENDENT CHILD												
DEPENDENT CHILD												

**If the weight change is due to a medical reason, please complete the Underwriting Questionnaire section found at the back of this application.*

3. COVERAGE PLAN APPLIED FOR AT THIS TIME You must select the same plan for all family members to be insured under your coverage.

- The Essential Plan – Health Only The Essential Plan – Health & Dental
 The Enhanced Plan – Health Only The Enhanced Plan – Health & Dental

All Applicants: This application is not valid unless the Underwriting Questionnaire section is properly completed and the application is signed.
Québec Residents: After completion, you may detach this section and send it directly to Manulife Financial in the enclosed business reply envelope.

4. UNDERWRITING QUESTIONNAIRE – PLEASE ENSURE THAT YOU HAVE ANSWERED ALL QUESTIONS ON BOTH SIDES.

NAME	NAME OF DOCTOR	DOCTOR'S TELEPHONE NO.	DATE AND REASON LAST CONSULTED	DIAGNOSIS/TREATMENT/MEDICATION GIVEN
MEMBER				
SPOUSE				

Has any individual proposed for coverage:

	Member		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including carrier state), kidney disorder, urinary abnormality, unusual infection or immune system abnormality, or other illness not mentioned?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Used drugs for other than medical purposes, been treated for or advised to reduce alcohol or drug use or used marijuana in the past 7 years?....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had back, neck, hip or knee trouble or been treated for chronic pain or fibromyalgia, had X-rays of spine or joints or been hospitalized or disabled by any injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had any positive test, treatment for or exposure to HIV or AIDS?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Female Applicants: Are you currently pregnant? If yes, give due date: _____ (mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last 2 years, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.), been advised to see another doctor or to have surgery or had an abnormal investigation or test result?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever engaged in or intend to engage in, any hazardous sport or activity, e.g., flying (except as a fare-paying passenger on a commercially licensed carrier), racing, scuba diving, climbing, etc.?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Smoked cigarettes in the last 12 months? (If other forms of tobacco used, give details.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever applied for any insurance that was declined, modified or rated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had his/her driver's licence suspended or been charged with impaired driving? If yes, provide driver's licence number: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Plan to reside outside of Canada? If yes, state country and date. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" to any of the questions above, please provide details on reverse. If you require additional space, please use a separate page, signed and dated.
 NOTE: Manulife Financial may request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV) which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

PLEASE COMPLETE BOTH SIDES

