

Application For Compassionate Assistance Loan Claimant's Statement

Instructions to Insured Person/Owner

- The insured person must be terminally ill with a life expectancy of 24 months or less. Eligibility for the loan is subject to Manulife Financial's terms and conditions. If the loan is approved, the necessary Loan Agreement forms will be prepared by Manulife Financial to be signed by the policy owner.
- The insured person completes pages 1 to 3.
- If the insured person is not the policy owner, then the policy owner must sign this Claimant's Statement. Any loan granted will be issued to the policy owner.
- The insured person's attending physician needs to complete pages 4 and 5.
- You are responsible for paying any fees charged to complete the Attending Physician's statement.
- If you have any questions, please contact your insurance advisor or phone our Valued Customer Centre at 1-888-626-8543. If you live in Quebec, call 1-888-626-8843.
- In this Claimant's Statement, *you* and *your* mean the insured person, except in the Signatures section where *you* and *your* may mean the policy owner if different from the insured person. *We*, *us* and *our* mean the insurer of the policy identified below.

1 Insured person's information	Policy number(s)	Name of insured person (first, middle initial, last)		
	Address of insured person		Date of birth (dd/mmm/yyyy)	
	City	Province	Postal code	
	Telephone number ()			
	Do you smoke or use other tobacco products? <input type="radio"/> Yes <input type="radio"/> No			
	If "Yes," please indicate amount per day: Cigarettes _____ Pipe _____ Other tobacco use _____			
	How long have you smoked or used tobacco?		Have you ever stopped smoking or using tobacco? <input type="radio"/> Yes <input type="radio"/> No	
		If "Yes," when _____ If "Yes", for how long? _____		
2 Loan details	Amount of loan requested	Choose one of the following payment options:		
	\$	<input type="radio"/> Pay by cheque <input type="radio"/> Pay by direct deposit (attach void cheque to this page)		
3 Claim information	Describe the nature and extent of your illness			
	What symptoms preceded diagnosis of the illness and when?			
	What treatment have you received and are currently receiving in connection with your illness? (eg. medication, therapy, surgery, etc.)			
	Type of treatment	Institution/Attending Physician		Date (dd/mmm/yyyy)

4 Information about your doctors

Please provide the following information about your family physician.

Name of doctor	
Address of doctor	
Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)

Please provide the following information about all doctors you have seen in the past 5 years. (If necessary, use a separate piece of paper)

Name of doctor	
Address of doctor	
Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)

Name of doctor	
Address of doctor	
Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)

Name of doctor	
Address of doctor	
Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)

Name of doctor	
Address of doctor	
Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)

Name of doctor	
Address of doctor	
Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)

5 Authorization and consent

Before signing, please read the following important information about the collection and use of any personal information connected to this Claimant's Statement.

Collecting, using and disclosing personal information

By signing below you consent that we may use your personal information that we collect to:

- confirm your identity and to otherwise uniquely identify you, and
- evaluate, determine eligibility for and administer the loan and any claims with respect to this policy.

By signing below you authorize any doctor, medical practitioner, health care professional, hospital, clinic and other medical or medically related facility, insurance company or other organization, institution, association or person that has any information, records or knowledge of you, to release to and exchange with us and applicable reinsurers any information about you that we require to evaluate or administer the loan.

Retaining personal information

By signing below you acknowledge that we will keep your personal information that we collect for the longer of:

- the time period required by law and by the guidelines set for the financial services industry, or
- the time period required to administer the loan and any subsequent claim with respect to this policy.

Accessing personal information

We protect personal information that we collect and keep it secure by storing it in an individual file. Only the following people or service providers may have access to personal information:

- our employees and agents who require this information to perform their jobs
- applicable reinsurers
- third-party service providers who require this information to provide services to us, which may include
 - claims investigators and investigative agencies
 - your insurance advisor and any insurance agency which employs the advisor or has named the advisor as its agent, either directly or indirectly, and their employees
- people to whom you have granted access, and
- people who are legally authorized to view the personal information.

Withdrawal of your consent

You may withdraw your consent for us to collect, use, disclose and retain the personal information that we need to evaluate and administer the loan.

If you withdraw your consent or if we do not have valid consent, as described in this Claimant's Statement, before the loan application is evaluated and processed, a loan will not be paid.

To withdraw your consent regarding our collection, use or disclosure of your personal information, you may contact us at any time by phoning our Valued Customer Centre at 1-888-626-8543 outside of Quebec, or 1-888-626-8843 in Quebec, or by writing to our Privacy Office at the address below.

Your right to access personal information or to receive additional information

You understand that your personal information will be used and stored as described in our policy and procedures document. This document is available from:

Manulife Financial
 Privacy Office - Individual Insurance
 25 Water Street South
 PO BOX 800 STN C
 KITCHENER ON N2G 4Y5

OR
 our website:
www.manulife.ca
 PRIVACY POLICY

6 Signatures

In this section *you* and *your* mean the insured person and the policy owner, if other than the insured.

By signing below you confirm that:

- to the best of your knowledge, all of the information in this Claimant's Statement is current, correct and complete
- you agree to the terms of this Claimant's Statement
- you make all declarations, acknowledgements and authorizations contained in this Claimant's Statement, and
- you agree that a photocopy of this authorization shall be as valid as the original.

Signature of insured person X	Date signed (dd/mmm/yyyy)
Signature of policy owner X	Date signed (dd/mmm/yyyy)

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Application For Compassionate Assistance Loan Attending Physician's Statement

- The concept behind the Compassionate Assistance Program is to advance funds from a life insurance policy prior to death for an individual diagnosed as having less than 24 months to live.
- The patient is responsible for any fee for completion of this form.
- By completing this Attending Physician's Statement, information contained on this form will become part of an Individual insurance file and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information on this form, you consent to the unedited release of that information.
- In this Attending Physician's Statement *you* and *your* mean the physician who completes it; *we*, *us* and *our* mean the company providing the insurance coverage on the patient named below.

1 Patient, diagnosis and prognosis information	Patient's name (first, middle initial, last)	
	Primary Diagnosis (please include copies of any surgical pathology reports/consultation reports that support the diagnosis)	
	Date symptoms began (dd/mmm/yyyy)	Date diagnosis made (dd/mmm/yyyy)
	What is the current status/stage of the disease?	
	What is the prognosis/expected life expectancy (in your opinion is life expectancy less than 24 months)?	
	Does the patient, to your knowledge, smoke or use tobacco products? <input type="radio"/> Yes <input type="radio"/> No	
	If "Yes," please indicate amount per day: Cigarettes _____ Pipe _____ Other tobacco use _____	
	How long has the patient smoked or used tobacco?	Has the patient ever stopped smoking or using tobacco? <input type="radio"/> Yes <input type="radio"/> No If "Yes," when _____ If "Yes", for how long? _____
2 Treatment information	Nature of treatment (provide course of treatment to date as well as planned treatments/procedures with regards to diagnosis)	

2 Treatment information (continued)

Have you treated or advised the patient during the last 5 years, prior to last illness? Yes No
 If "Yes," provide the following details:

Nature of illness	Approximate date (dd/mmm/yyyy)

Did the patient, to your knowledge, receive treatment during the last five years from any other physician, hospital or institution? Yes No If "Yes," please provide the following details:

Name (physician, hospital)	Address
Nature of illness	Approximate date (dd/mmm/yyyy)
Name (physician, hospital)	Address
Nature of illness	Approximate date (dd/mmm/yyyy)
Name (physician, hospital)	Address
Nature of illness	Approximate date (dd/mmm/yyyy)

3 Physician's signature

By signing below you confirm that:

- you understand that we may share the information you provide with the patient, applicable reinsurers, third party administrators and, where authorized by law, with other insurance companies to allow them to administer insurance with respect to the patient, and
- to the best of your knowledge, the information on this statement about the patient is current, correct and complete.

Physician's name (first, middle initial, last) (please print)		
Physician's address		
City	Province	Postal code
Signature X		Date signed (dd/mmm/yyyy)