

Application for change

when evidence of insurability is required


This form can be used to make a change to a life, disability or critical illness insurance policy, or a Synergy combined insurance solution insured by any of the companies (known as “Manulife companies”) listed on the bottom of this page. To make a change to a long term care policy, use *Policy change or reinstatement – Long term care*, NN1548E.

Unless otherwise noted in a specific section, *you* and *your* refer to the policy owner and *we*, *us* and *our* refer to the company that currently insures the policy identified in this application. If your requested change results in a new policy issued by the other Manulife company, *we*, *us*, and *our* can also refer to the company that will insure the new policy.

For Synergy, the word *policy* also refers to *solution*.

Section 1 – Information about the change

1.1 Tell us the policy number and the name of the owner of the policy you want to change.

 Policy number	Name of policy owner (first, middle initial, last) or full legal name of corporation
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1.2 Changes to any type of policy (Select all that apply.)

Change requested	Information required				
<input type="checkbox"/> Change status from smoker to non-smoker (for a policy or rider issued without Healthstyle categories)	For a life or critical illness policy, or a Synergy solution: Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor’s report For a disability policy: Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor’s report				
<input type="checkbox"/> Change Healthstyle category (for a policy or rider issued with Healthstyle categories)	from Healthstyle <input type="text"/> to Healthstyle <input type="text"/> Healthstyle 1 means no use of tobacco or nicotine products for more than 15 years, excellent health and a low-risk lifestyle. Healthstyle 2 means no use of tobacco or nicotine products for more than two years, very good health and a low-risk lifestyle. Healthstyle 3 means no use of tobacco or nicotine products for more than one year, good health and standard lifestyle. Healthstyle 4 means use of tobacco or nicotine products other than cigarettes and/or marijuana. Healthstyle 5 means use of cigarettes and/or marijuana. Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor’s report				
<input type="checkbox"/> Reinstate policy OR	<table border="1"> <tr> <td>Date of lapse</td> <td>Amount of payment made for any outstanding premium (including any outstanding loans and interest)</td> </tr> <tr> <td><input type="text"/></td> <td>\$ <input type="text"/></td> </tr> </table>	Date of lapse	Amount of payment made for any outstanding premium (including any outstanding loans and interest)	<input type="text"/>	\$ <input type="text"/>
Date of lapse	Amount of payment made for any outstanding premium (including any outstanding loans and interest)				
<input type="text"/>	\$ <input type="text"/>				
<input type="checkbox"/> Reinstate automatic coverage enhancement (for a disability policy)	For a life or critical illness policy, or a Synergy solution: Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor’s report For a disability policy: Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor’s report Send us: <input type="checkbox"/> outstanding premium payment/deposit <input type="checkbox"/> <i>Identifying owners of Individual Insurance policies</i> , NN1558E (For universal life and Performax Gold policies only)				
<input type="checkbox"/> Improve insurance rating OR	For a life or critical illness policy, or a Synergy solution: Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor’s report				
<input type="checkbox"/> Reconsider exclusion	For a disability policy: Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor’s report				

Section 1 – Information about the change (continued)

1.3 Changes to a disability policy (Select all that apply.)

▶▶ Do not complete for any changes to a Synergy solution.

Change requested	Information required
<input type="checkbox"/> Change occupation class	from <input type="text"/> to <input type="text"/> Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report
<input type="checkbox"/> Increase monthly benefit (for a Proguard or Venture policy issued after June 11, 2004) <small>For a Proguard or Venture policy issued before June 11, 2004, or for other disability products, use <i>Application for life, disability and critical illness insurance</i>, NN7000E.</small>	from \$ <input type="text"/> to \$ <input type="text"/> Complete sections: 1, 2, 3.1, 5.1-5.5, 6, 7, 11, 12 and the Advisor's report Send us: <input type="checkbox"/> premium payment
<input type="checkbox"/> Decrease elimination period	from <input type="text"/> to <input type="text"/> Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report
<input type="checkbox"/> Remove Income Loss Replacement Plan (ILRP) (for a disability policy issued in the past 5 years if the amount of insurance is not changing)	Complete sections: 1, 2, 3.1, 11.1–11.3, 12 and the Advisor's report
<input type="checkbox"/> Increase benefit period	from <input type="text"/> to <input type="text"/> Complete sections: 1, 2, 3.1, 5.1–5.5, 6, 7, 11, 12 and the Advisor's report
<input type="checkbox"/> Convert disability insurance	Select one. <input type="checkbox"/> convert Buy-Sell Plus to <input type="checkbox"/> Proguard OR <input type="checkbox"/> Venture <input type="checkbox"/> convert ExpenseComp or OfficeGuard to <input type="checkbox"/> Proguard OR <input type="checkbox"/> Venture <input type="checkbox"/> convert IncomePlus to <input type="checkbox"/> Proguard OR <input type="checkbox"/> Venture Complete sections: 1, 2, 3.1, 11.1–11.3, 12 and the Advisor's report Send us: <input type="checkbox"/> premium payment <input type="checkbox"/> original policy

1.4 Changes to a life or critical illness policy, or a Synergy solution (Select all that apply.)

Change requested	Information required			
<input type="checkbox"/> Add or increase a child rider	<input type="checkbox"/> Add a new child protection rider on a life insurance policy or a new child protection rider–life on a Synergy solution. <input type="checkbox"/> Add a new children's Lifecheque rider on a Lifecheque policy or a new child protection rider–critical illness on a Synergy solution. Amount of insurance \$ <input type="text"/> <input type="checkbox"/> Increase an existing children's Lifecheque rider or child protection rider–critical illness from \$ <input type="text"/> to \$ <input type="text"/> Complete sections: 1, 2, 3.3, 5.1 d, 5.5, 6, 7, 8, 10, 12 and the Advisor's report			
<input type="checkbox"/> Add a coverage OR <input type="checkbox"/> Add a new insured person	<table border="1"> <tr> <td>Coverage amount \$ <input type="text"/></td> <td>Coverage type <input type="text"/></td> <td>Coverage option/COI <input type="text"/></td> </tr> </table> For a Performax Gold policy, you must also tell us: 1. Which performance credit option you would like? <input type="checkbox"/> accumulation account <input type="checkbox"/> paid-up insurance <input type="checkbox"/> term option <input type="text"/> Term option amount \$ <input type="text"/>	Coverage amount \$ <input type="text"/>	Coverage type <input type="text"/>	Coverage option/COI <input type="text"/>
Coverage amount \$ <input type="text"/>	Coverage type <input type="text"/>	Coverage option/COI <input type="text"/>		

Section 1 – Information about the change (continued)

Change requested

If the planned first year additional payment amount is less than or equal to the threshold amount, complete *Deposit option*, NN0713E. See the *Performax Gold Product and Administrative Guide* for instructions on calculating the evidence of insurability requirement threshold.

Information required

2. Do you want to add an Early Cash Value Enhancer rider to this coverage? No Yes
3. Do you want to add deposit option insurance to this coverage? No Yes If yes, tell us:

a. Planned first coverage year deposit option payment \$

for years OR

planned lifetime deposit option payments \$

b. Additional amount you want to be billed \$

c. Additional amount you want added to your existing automatic monthly withdrawal \$

d. Allocation instructions for additional payments
These instructions apply to (select one or both):

this additional payment of \$

all future additional payments

Tell us how you want to allocate your additional payment. % of additional payment allocated

To deposit option insurance coverage number	<input type="text"/>	%
To deposit option insurance coverage number	<input type="text"/>	%
To deposit option insurance coverage number	<input type="text"/>	%
To accumulation account	<input type="text"/>	%

Total 100%

Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report

Increase amount of insurance

from \$ to \$

For:
Family Term, Business Term, Limited Pay UL, Security UL, Security Universal Life or InnoVision,
OR
a term insurance rider on Performax Gold or Synergy,
you must choose one option below:

replace existing coverage with current-dated coverage for the higher amount

OR

add a new layer of coverage for the amount of the increase only

Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report

Add rider or benefit for a person insured on that policy

Name of rider or benefit	Amount of addition
<input type="text"/>	\$ <input type="text"/>

Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report

Send us: financial statements for the business the coverage applies to for the last three consecutive fiscal years (if adding a BVP rider)

documentation showing the current equity position of each insured person in this business (if adding a BVP rider)

Change death benefit type (If net amount at risk increases)

to

If net amount at risk does not increase, use *Request for change*, NN0739E.

Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report

Switch cost type and/or duration

For a Synergy solution, a change in cost type applies to all policies.

for all coverages OR for Coverage number OR for Synergy

from to

Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report

Decrease waiting period to 90 days (for the disability insurance policy in a Synergy solution)

Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report

Section 1 – Information about the change (continued)

Change requested	Information required												
<input type="checkbox"/> Plan change or plan exchange If no evidence of insurability is required, use <i>Plan exchange or plan change application</i> , NN1556E.	from <input style="width: 200px;" type="text"/> to <input style="width: 200px;" type="text"/> Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 and the Advisor's report Send us: <input type="checkbox"/> product page for new plan (for Innovision, Security UL, Limited Pay UL, Performax Gold, Family Term Life, Business Term Life or Lifecheque only) <input type="checkbox"/> signed illustration for new plan (for Innovision, Security UL, Limited Pay UL and Performax Gold only)												
<input type="checkbox"/> Change performance credit option (for a Performax Gold policy) Use <i>Request for change</i> , NN0739E if you are changing: <ul style="list-style-type: none"> • from term option to paid-up insurance • from term option to accumulation account or • from paid up insurance to accumulation account. 	for <input style="width: 150px;" type="text"/> Coverage number Select one. <input type="checkbox"/> from accumulation account to paid-up insurance <input type="checkbox"/> from accumulation account to term option <input style="width: 100px;" type="text"/> Term option amount \$ <input type="checkbox"/> from paid-up insurance to term option <input style="width: 100px;" type="text"/> Term option amount \$ Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report												
<input type="checkbox"/> Change dividend option (If net amount at risk increases) If net amount at risk does not increase, complete <i>Request for change</i> , NN0739E.	from <input style="width: 200px;" type="text"/> to <input type="checkbox"/> paid-up insurance OR <input type="checkbox"/> term option Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor's report												
<input type="checkbox"/> Apply for select rates (for a Commercial Union policy)	Complete sections: 1, 2, 3, 5.1–5.7, 6, 7, 8, 12 and the Advisor's report												
<input type="checkbox"/> Deposit option change requiring underwriting	<input type="checkbox"/> Add deposit option insurance for coverage number <input style="width: 100px;" type="text"/> a. Planned first coverage year deposit option payment <input style="width: 100px;" type="text"/> \$ <input type="checkbox"/> for <input style="width: 50px;" type="text"/> years OR <input type="checkbox"/> planned lifetime deposit option payments <input style="width: 100px;" type="text"/> \$ b. Additional amount you want to be billed <input style="width: 100px;" type="text"/> \$ c. Additional amount you want added to your existing automatic monthly withdrawal <input style="width: 100px;" type="text"/> \$ d. Allocation instructions for additional payments These instructions apply to (select one or both): <input type="checkbox"/> this additional payment of <input style="width: 100px;" type="text"/> \$ <input type="checkbox"/> all future additional payments Tell us how you want to allocate your additional payment. <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 30%;">% of additional payment allocated</th> </tr> </thead> <tbody> <tr> <td>To deposit option insurance coverage number</td> <td style="text-align: center;"><input style="width: 50px;" type="text"/> %</td> </tr> <tr> <td>To deposit option insurance coverage number</td> <td style="text-align: center;"><input style="width: 50px;" type="text"/> %</td> </tr> <tr> <td>To deposit option insurance coverage number</td> <td style="text-align: center;"><input style="width: 50px;" type="text"/> %</td> </tr> <tr> <td>To accumulation account</td> <td style="text-align: center;"><input style="width: 50px;" type="text"/> %</td> </tr> <tr> <td style="text-align: right;">Total</td> <td style="text-align: center;">100%</td> </tr> </tbody> </table> Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report		% of additional payment allocated	To deposit option insurance coverage number	<input style="width: 50px;" type="text"/> %	To deposit option insurance coverage number	<input style="width: 50px;" type="text"/> %	To deposit option insurance coverage number	<input style="width: 50px;" type="text"/> %	To accumulation account	<input style="width: 50px;" type="text"/> %	Total	100%
	% of additional payment allocated												
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To deposit option insurance coverage number	<input style="width: 50px;" type="text"/> %												
To deposit option insurance coverage number	<input style="width: 50px;" type="text"/> %												
To accumulation account	<input style="width: 50px;" type="text"/> %												
Total	100%												
<input type="checkbox"/> Increase the existing deposit option insurance coverage limit for coverage <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Increase the annual limit to <input style="width: 100px;" type="text"/> \$ Additional amount you want to be billed <input style="width: 100px;" type="text"/> \$ Additional amount you want added to your existing automatic monthly withdrawal <input style="width: 100px;" type="text"/> \$ <input type="checkbox"/> Increase the lifetime limit to <input style="width: 100px;" type="text"/> \$ Complete sections: 1, 2, 3, 5, 6, 7, 8, 12 and the Advisor's report												

Section 1 – Information about the change (continued)

Change requested	Information required																										
<p><input type="checkbox"/> Exercise GIO or BVP option</p> <p>If no evidence of insurability is required, use <i>Term conversion application or exercising a GIO or BVP</i>, NN0431E.</p> <p>For a Performax Gold policy, if you are requesting deposit option, see <i>Performax Gold Administration guide</i> to determine if you also need to complete <i>Deposit option</i>, NN0713E.</p>	<p><input type="checkbox"/> business value protector option</p> <p>OR</p> <p><input type="checkbox"/> guaranteed insurability option</p> <p style="margin-left: 20px;"><input type="checkbox"/> age <input type="checkbox"/> policy anniversary <input type="checkbox"/> alternative</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Option date (dd/mmm/yyyy)</td> <td>Event establishing alternative option (Example: birth of child)</td> </tr> <tr> <td colspan="2">What proof of the event is being submitted? (Example: birth certificate)</td> </tr> </table> <p>Complete sections: 1, 2, 3, 4, 9, 12 and the Advisor's report</p> <p>Send us: <input type="checkbox"/> signed product page <input type="checkbox"/> signed illustration <input type="checkbox"/> premium payment/deposit <input type="checkbox"/> void cheque and/or automatic monthly withdrawal details (if applicable) <input type="checkbox"/> financial statements for the business the coverage applies to for the last three consecutive fiscal years (if exercising BVP) <input type="checkbox"/> documentation showing the current equity position of each insured person in this business (if exercising BVP)</p>	Option date (dd/mmm/yyyy)	Event establishing alternative option (Example: birth of child)	What proof of the event is being submitted? (Example: birth certificate)																							
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What proof of the event is being submitted? (Example: birth certificate)																											
<p><input type="checkbox"/> Exercise option to purchase permanent life insurance at expiry (for a Synergy solution)</p> <p>If no evidence of insurability is required, use <i>Request for change</i>, NN0739E.</p>	<p>Complete sections: 1, 2, 3, 4, 9, 12 and the Advisor's report</p> <p>Send us: <input type="checkbox"/> signed product page <input type="checkbox"/> signed illustration (if required) <input type="checkbox"/> premium payment/deposit <input type="checkbox"/> void cheque and/or automatic monthly withdrawal details (if applicable)</p>																										
<p><input type="checkbox"/> Convert term insurance</p> <p>If you are not making any other changes to your policy or if no evidence of insurability is required, use <i>Term conversion application or exercising a GIO or BVP</i>, NN0431E.</p> <p>For a Performax Gold policy, if you are requesting deposit option, see <i>Performax Gold Administration guide</i> to determine if you also need to complete <i>Deposit option</i>, NN0713E.</p> <p>Note: There may be a taxable gain if the term policy you are converting has cash value at the time of conversion.</p>	<p>a. How do you want the new insurance to be issued?</p> <p><input type="checkbox"/> issue the new insurance on a new policy <input type="checkbox"/> issue the policy in English OR <input type="checkbox"/> établir le contrat en français</p> <p>OR</p> <p><input type="checkbox"/> issue the new insurance as a new coverage on existing policy Policy number</p> <p>b. If there is a disability waiver rider on the policy you want to convert, are any people insured by that rider currently totally disabled and unable to perform the duties of their regular occupation? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Converting an individual policy or rider (If you want to terminate any insurance other than term, complete <i>Policy surrender</i>, NN0387E.)</p> <p>The insurance being converted is contained in the:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> term insurance rider</td> <td><input type="checkbox"/> spouse protection rider</td> <td><input type="checkbox"/> child rider</td> <td style="border: 1px solid black; padding: 2px;">Child's date of birth</td> </tr> <tr> <td><input type="checkbox"/> survivor's benefit</td> <td><input type="checkbox"/> term option (multiplier dividend option)</td> <td><input type="checkbox"/> other</td> <td style="border: 1px solid black; padding: 2px;"></td> </tr> </table> <p>d. Tell us the following information about the insurance you are converting:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Name of insured person (first, middle initial, last)</td> <td style="width: 33%;">Coverage date (dd/mmm/yyyy)</td> <td style="width: 33%;">Current term coverage amount \$</td> </tr> <tr> <td>Amount of current term coverage to be converted \$</td> <td>Amount of current term coverage to be cancelled \$</td> <td>Amount of current term coverage to remain in the original policy or in a new term rider \$</td> </tr> </table> <p>e. Which of the following riders or benefits do you want to transfer to the new policy?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Rider or benefit</th> <th style="width: 25%;">Amount of coverage to transfer to new policy</th> <th style="width: 25%;">Rider or benefit</th> <th style="width: 25%;">Amount of coverage to transfer to new policy</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> accidental death benefit</td> <td>\$</td> <td><input type="checkbox"/> child rider child's date of birth:</td> <td>\$</td> </tr> <tr> <td><input type="checkbox"/> disability waiver rider</td> <td>N/A</td> <td><input type="checkbox"/> child rider child's date of birth:</td> <td>\$</td> </tr> </tbody> </table>	<input type="checkbox"/> term insurance rider	<input type="checkbox"/> spouse protection rider	<input type="checkbox"/> child rider	Child's date of birth	<input type="checkbox"/> survivor's benefit	<input type="checkbox"/> term option (multiplier dividend option)	<input type="checkbox"/> other		Name of insured person (first, middle initial, last)	Coverage date (dd/mmm/yyyy)	Current term coverage amount \$	Amount of current term coverage to be converted \$	Amount of current term coverage to be cancelled \$	Amount of current term coverage to remain in the original policy or in a new term rider \$	Rider or benefit	Amount of coverage to transfer to new policy	Rider or benefit	Amount of coverage to transfer to new policy	<input type="checkbox"/> accidental death benefit	\$	<input type="checkbox"/> child rider child's date of birth:	\$	<input type="checkbox"/> disability waiver rider	N/A	<input type="checkbox"/> child rider child's date of birth:	\$
<input type="checkbox"/> term insurance rider	<input type="checkbox"/> spouse protection rider	<input type="checkbox"/> child rider	Child's date of birth																								
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Rider or benefit	Amount of coverage to transfer to new policy	Rider or benefit	Amount of coverage to transfer to new policy																								
<input type="checkbox"/> accidental death benefit	\$	<input type="checkbox"/> child rider child's date of birth:	\$																								
<input type="checkbox"/> disability waiver rider	N/A	<input type="checkbox"/> child rider child's date of birth:	\$																								

Section 1 – Information about the change (continued)

Change requested

Information required

f. For a child rider with a critical illness insurability benefit

If you are applying to convert a child rider with a critical illness insurability benefit, the insured person must answer the following questions:

1. **Do you have or have you applied for critical illness insurance that provides a total of \$1,900,000 or more coverage with The Manufacturers Life Insurance Company and other insurance companies?**
 No Yes
2. **Have you ever been diagnosed with cancer of any kind, heart attack, coronary artery disease requiring surgery or any condition requiring coronary angioplasty, stroke, multiple sclerosis, blindness, deafness, loss of speech, kidney failure, paralysis, loss of limbs, coma, Alzheimer's disease, motor neuron disease, HIV, Parkinson's disease, severe burns, benign brain tumour or have you been placed on the waiting list for or undergone a major organ transplantation, or undergone aortic surgery or heart valve replacement, or do you require assistance to perform any of the routine activities of daily living, including bathing, dressing, eating, toileting, transferring and maintaining continence?**
 No Yes

If you answered **yes** to question 1 or 2 we regret that we cannot offer you critical illness insurance without additional evidence of your insurability. If you want to apply for critical illness insurance by providing evidence of insurability, complete and submit the *Application for life, disability, and critical illness insurance*, NN7000E.

If you answered **no** to questions 1 and 2 tell us the amount of insurance you want to purchase. You may buy a combination of life insurance and critical illness insurance as long as the total amount of insurance is not more than \$250,000 and the critical illness portion of the total insurance is not more than \$100,000.

Amount of life insurance \$	Amount of critical illness insurance \$
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Complete sections: 1, 2, 3, 4, 9, 12 and the Advisor's report

- Send us:**
- signed product page (for InnoVision, UltraVision, Performax Gold, Security UL, Limited Pay UL, Family Term or Business Term only)
 - signed illustration (for InnoVision, UltraVision, Performax Gold, Security UL or Limited Pay UL only)
 - premium payment/deposit
 - void cheque and/or automatic monthly withdrawal details (if applicable)

Cancel joint last-to-die UltraVision policy and issue current-dated single life policy(ies)

Tell us what you want us to do with any remaining account value on this joint last-to-die coverage? (Select one.)

- issue *one* new current-dated single life policy and transfer any remaining account value to the new policy

Complete sections: 1, 2, 3, 4, 5, 6, 7, 8, 9, 12 and the Advisor's report

- Send us:**
- UltraVision product page*, NN1588E, for the new current-dated single-life policy
 - signed Illustration for the new current-dated single-life policy

OR

- issue *two* new current-dated single-life policies and split any remaining account value between the new policies as described below.*

1. For the first new current-dated single life policy:

Complete the following sections in *this Application for change*, NN7001E: 1, 2, 3, 4, 5, 6, 7, 8, 9, 12 and the Advisor's report

- Send us:**
- UltraVision product page*, NN1588E, for the new current-dated single-life policy
 - signed Illustration for the new current-dated single-life policy

Tell us:

Name of insured person (first, middle initial, last)	Percentage of account value from original joint-last-to-die coverage to be transferred into the new policy %
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2. For the second new current-dated single life policy:

Complete the following sections in a *separate Application for change*, NN7001E: 1, 2, 3, 4, 5, 6, 7, 8, 9, 12 and the Advisor's report

- Send us:**
- UltraVision product page*, NN1588E, for the new current-dated single-life policy
 - signed Illustration for the new current-dated single-life policy

Tell us:

Name of insured person (first, middle initial, last)	Percentage of account value from original joint-last-to-die coverage to be transferred into the new policy %
Application number for the separate Application for change	

* If you are requesting a change to issue two new current-dated single life policies, you must submit all the required forms for both applications.

Other

Provide details about the change you want to make

Before you buy

If you want more information about the insurance product you are considering, visit our client website at www.manulife.ca/b4ubuy

Where to send the completed form

Send this completed application and any additional documents required to:

Manulife Financial
500 King Street North
PO BOX 1669
WATERLOO ON N2J 4Z6

Financière Manuvie
2000 rue Mansfield, bureau 1310
MONTREAL QC H3A 3A1

To help you use this form



If your client is applying for a child rider or adding a child to an existing rider, provide all requested information about the children to be insured where you see this icon. It helps you locate the information we need for a child rider. If a child is to be one of the people insured on this policy, provide the information for that child in the "Person A" or "Person B" boxes; do not provide information in the boxes labeled "Children under a child rider".



Essential items of information that we need to ensure this application is processed without delay are highlighted with this symbol in the margin and a bold fill-in box.

▶▶ This fast forward symbol appears throughout the form with instructions to help you determine if a section is required for the change you are making.

Section 2 – General information

2.1 Direct deposit for refunds

If your policy change produces a refund, deposit it to:

the bank account from which we are taking your automatic monthly withdrawal for policy number

OR

the bank account identified in section 9.6 (for term conversions)

2.2 Do either of the following apply to this application?

▶▶ Complete this section only if you are applying for a change to your life insurance.

- Is any new person to be insured over 70?
- Are you applying for insurance over \$2,000,000 on any of the people to be insured?
 No Yes If yes, answer the following questions:

a. Will the money to pay the premiums for this policy be borrowed from a bank or other institution?

No Yes If yes, provide details.

b. Is there an existing or planned agreement that provides for anyone other than the existing owner or the owner identified in section 9 to obtain any legal interest in any policy resulting from this application? No Yes If yes, provide details.

2.3 Special instructions

Section 3 – Information about the people to be insured

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. The questions must be answered by the people to be insured. If a person to be insured is a minor, the minor's parent or guardian (tutor, in Quebec) must provide the information on their behalf. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider.

3.1 Person "A" to be insured

a. Legal name (first, middle initial, last)		Date of birth (dd/mmm/yyyy)		Sex <input type="checkbox"/> male <input type="checkbox"/> female	
Address (street and number)		Apt.	City or town		Province
Postal code	Number of years at this address	Home telephone number ()	Preferred contact number ()	Place of birth (province and country)	

b. Are you a Canadian citizen or do you have permanent resident status?

<input type="checkbox"/> No If <i>no</i> , provide details.	Previous country of residence	Your current immigration status in Canada	When did this status come into effect? (dd/mmm/yyyy)
<input type="checkbox"/> Yes			

3.2 Person "B" to be insured

a. Legal name (first, middle initial, last)		Date of birth (dd/mmm/yyyy)		Sex <input type="checkbox"/> male <input type="checkbox"/> female	
Address (street and number)		Apt.	City or town		Province
Postal code	Number of years at this address	Home telephone number ()	Preferred contact number ()	Place of birth (province and country)	

b. Are you a Canadian citizen or do you have permanent resident status?



<input type="checkbox"/> No If <i>no</i> , provide details.	Previous country of residence	Your current immigration status in Canada	When did this status come into effect? (dd/mmm/yyyy)
<input type="checkbox"/> Yes			

3.3 Children to be insured under a child rider

▶▶ Complete this section only if you are applying for a child rider. Otherwise go to section 4.


In this section, *you* and *your* refer to the policy owner and the people to be insured. Evidence of insurability may be required for each child and the person or people insured under the policy.

a. Tell us the following information for each child to be insured under this rider.

Child 1 	Name (first, middle initial, last)	<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> legally adopted child	Sex <input type="checkbox"/> male <input type="checkbox"/> female	Date of birth (dd/mmm/yyyy)
Child 2 	Name (first, middle initial, last)	<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> legally adopted child	Sex <input type="checkbox"/> male <input type="checkbox"/> female	Date of birth (dd/mmm/yyyy)

b. Do all the children to be insured under this rider live with you or the policy owner? Yes No

If *no*, who do the children live with?

Child 1 	Name of caregiver (first, middle initial, last)	Relationship to child
--	---	-----------------------

When did this child last visit either the people to be insured or the policy owner?	Date (dd/mmm/yyyy)	How often does this child visit either the people to be insured or the policy owner?
---	--------------------	--

Child 2 	Name of caregiver (first, middle initial, last)	Relationship to child
--	---	-----------------------

When did this child last visit either the people to be insured or the policy owner?	Date (dd/mmm/yyyy)	How often does this child visit either the people to be insured or the policy owner?
---	--------------------	--

Section 4 – Beneficiary information

In this section, *you* and *your* refer to the policy owner.

By completing this section you are asking us to change the information you previously provided. **Any previous beneficiary designation or trustee appointment is revoked, even if this application for change is not approved.**

▶▶ **Complete this section for life insurance policies only (including life insurance under Synergy).**

For critical illness and disability insurance (including critical illness and disability insurance under Synergy)

To direct payment of benefits in all provinces except Quebec and Manitoba, use:

- For Lifecheque, *Direction to pay for Lifecheque policies*, NN0999E
- For Synergy, *Beneficiary designation and direction to pay for Synergy*, NN1609E

To designate beneficiaries in Quebec or Manitoba, use:

- For Lifecheque, *Beneficiary designations for Lifecheque policies*, NN1467E
- For Synergy, *Beneficiary designation and direction to pay for Synergy*, NN1609E
- For disability or critical illness (except Lifecheque and Synergy), *Beneficiary designations for disability policies or critical illness policies (except Lifecheque and Synergy)*, NN1584E

Choosing a beneficiary

You may choose one or more than one beneficiary for each insured person. The beneficiary receives the benefit if they are alive and eligible, as described below, when the death of the insured person results in the payment of a death benefit. If you want to choose a different beneficiary for a rider or a specific coverage, complete and submit *Beneficiary designation at a coverage level*, NN0772E, or for Synergy, *Beneficiary designation and direction to pay for Synergy*, NN1609E.

If you name more than one beneficiary, tell us the percentage of the death benefit each beneficiary is to receive. Otherwise, we will divide the death benefit evenly among the surviving eligible beneficiaries.

You may choose both beneficiaries and secondary beneficiaries. A secondary beneficiary will only receive a death benefit if no beneficiaries are eligible to receive the benefit. A beneficiary is not eligible to receive a

benefit if they die before the benefit is payable or they are otherwise disqualified.

About irrevocable beneficiary designations

If you name an irrevocable beneficiary, you cannot make changes to the policy, assign its benefits or cash value, withdraw funds from it or transfer its ownership without the beneficiary's written approval. Parents or guardians (tutors, in Quebec) of irrevocable beneficiaries who are children cannot give approval on their behalf. Approval must come directly from the beneficiary, and a minor beneficiary cannot give consent.

In all provinces except Quebec, beneficiary designations are revocable, unless you select **irrevocable**.

In Quebec, beneficiary designations of married or civil union spouses are irrevocable, unless you select **revocable**. All other beneficiary designations are revocable, unless you select **irrevocable**.

4.1 Beneficiaries – Person “A” to be insured

a. Beneficiaries

Name of beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %
Name of beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %

b. Secondary beneficiaries

Total 100%

Name of secondary beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %
Name of secondary beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %

Total 100%

4.2 Beneficiaries – Person “B” to be insured

a. Beneficiaries

Name of beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %
Name of beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %

b. Secondary beneficiaries

Total 100%

Name of secondary beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %
Name of secondary beneficiary (first, middle initial, last)	Relationship*	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable	Share %

Total 100%

* **In Quebec**, tell us the beneficiary's relationship to the owner.

In all provinces except Quebec, tell us the beneficiary's relationship to the person to be insured.

4.3 Trustee for minor beneficiaries (not applicable in Quebec)

We recommend that you complete this section if a beneficiary you've named above is a minor. By completing this section, you agree that any benefit that becomes payable to a minor child will be paid to the trustee to hold in trust for the child until the child comes of age.

Name of beneficiary (first, middle initial, last)	Name of trustee (first, middle initial, last)	Relationship of trustee to beneficiary
Name of beneficiary (first, middle initial, last)	Name of trustee (first, middle initial, last)	Relationship of trustee to beneficiary

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intentionally.**

Section 5 – Personal information

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider. All people to be insured must complete this section.

5.1 Residency and travel

a. Do you expect to change your country of residence?

Person "A" to be insured

No Yes If yes, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing tell us what your new occupation will be.

Details

Person "B" to be insured

No Yes If yes, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing tell us what your new occupation will be.

Details

b. Do you expect to travel outside Canada and the United States within the next 12 months?

Person "A" to be insured

No Yes If yes, provide details.

Countries and cities you will visit	Length of stay in each

Person "B" to be insured

No Yes If yes, provide details.

Countries and cities you will visit	Length of stay in each



c. Purpose of travel for business as a tourist to visit family

other

Purpose of travel for business as a tourist to visit family

other

d. Will any children to be insured under a rider change their country of residence or travel outside Canada and the United States within the next 12 months? No Yes If yes, provide details, including what countries you will visit, the length of time in each country and the reason for travelling.

 Name of child	Details
 Name of child	Details

! All questions in section 5.2 a - h must be answered.

5.2 Smoking and tobacco use

Have you ever smoked or used any of the following?	Person "A" to be insured	If yes, provide details, including average amount used, how often, length of time used and the last date used.	Person "B" to be insured	If yes, provide details, including average amount used, how often, length of time used and the last date used.
a. Cigarettes	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
b. Marijuana	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
c. Cigars	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
d. Pipe	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
e. Cigarillos	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
f. Chewing tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
g. Nicotine substitutes (such as gum or patches)	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
h. Other _____ (specify) (Example: betel nuts)	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	

Return sections 5 through 7 to: Manulife Financial, 500 King Street North, PO BOX 1669, WATERLOO ON N2J 4Z6

Section 5 – Personal information (continued)

5.3 Alcohol and drug use

a. Have you ever consumed alcohol?

Person "A" to be insured

- No If *no*, you do not need to complete the rest of question a. Go to question b.
- Yes If yes, answer the following question and provide details.

Do you currently drink alcohol?

- Yes If yes, provide details.

Beer	Number	bottles per	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year
Wine	Number	glasses per	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year
Liquor	Number	oz/ml per	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year

- No If *no*, describe any past drinking behaviour, including why you stopped drinking.

Details

Person "B" to be insured

- No If *no*, you do not need to complete the rest of question a. Go to question b.
- Yes If yes, answer the following question and provide details.

Do you currently drink alcohol?

- Yes If yes, provide details.

Beer	Number	bottles per	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year
Wine	Number	glasses per	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year
Liquor	Number	oz/ml per	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year

- No If *no*, describe any past drinking behaviour, including why you stopped drinking.

Details

b. Have you ever used unprescribed drugs or experimented with drugs or narcotics such as ecstasy, cocaine, LSD, heroin, amphetamines, barbiturates, anabolic steroids or similar agents?

Person "A" to be insured

- No Yes If yes, provide details, including what you used, how often, and the last time you used it.

Details

Person "B" to be insured

- No Yes If yes, provide details, including what you used, how often, and the last time you used it.

Details

c. Have you ever been treated or counselled for alcohol or drug abuse, or has someone ever recommended that you seek treatment or counselling or reduce your alcohol or drug consumption?

Person "A" to be insured

- No Yes If yes, complete the alcohol usage section or drug usage section in *Underwriting questionnaires*, NN9434E, as applicable.

Person "B" to be insured

- No Yes If yes, complete the alcohol usage section or drug usage section in *Underwriting questionnaires*, NN9434E, as applicable.

5.4 Driving history

If you answer yes to any question in section 5.4, tell us the details below.

a. In the past two years, have you been charged with or convicted of any motor vehicle or traffic violation (such as speeding, illegal lane changes or seatbelt violations)? If yes, provide details, including the number of charges and convictions and the date of the last conviction.

Person "A" to be insured	Person "B" to be insured
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

b. In the past five years, have you been charged with or convicted of careless or dangerous driving or refusing a breathalyzer test or had your license suspended or revoked? If yes, provide details, including the number of charges and convictions and the date of the last conviction. In the case of a license suspension or revocation, provide details, including the date the license was suspended or revoked.

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
--	--

c. In the past 10 years, have you been charged with or convicted of operating a motor vehicle either while impaired by alcohol or drugs or with a blood alcohol level over the legal limit? If yes, provide details, including the number of charges and convictions and the date of the last conviction.

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
--	--

Person to be insured | **Question** | **Details (type of charge, number of charges, date). List all charges.**

<input type="checkbox"/> Person "A" to be insured <input type="checkbox"/> Person "B" to be insured		
<input type="checkbox"/> Person "A" to be insured <input type="checkbox"/> Person "B" to be insured		
<input type="checkbox"/> Person "A" to be insured <input type="checkbox"/> Person "B" to be insured		

d. Tell us your driver's licence number and where it was issued if:

- you are applying for coverage over \$1,000,000, or
- you answered yes to any of the questions in section 5.4.

Person "A" to be insured

Driver's licence number	Where it was issued

Person "B" to be insured

Driver's licence number	Where it was issued



If you live in British Columbia, Manitoba, Quebec, NWT or the Yukon, you must also complete a *Motor Vehicle Record Authorization form*.

Section 5 – Personal information (continued)

5.5 Other information

If you answer yes to any question in section 5.5, tell us the details below.

	Person "A" to be insured	Person "B" to be insured	 Children under a child rider
a. Have you ever had an application for life, disability, critical illness or long term care insurance declined, rated, postponed, cancelled or modified in any way? If yes, provide details, including the dates, name and type of coverage and the name of the insurance company.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
b. Have you ever been charged with or convicted of any criminal offence? If yes, provide details, including the nature of each offence, the date charged, the sentence and the date the sentence and any probation was completed.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. In the past 10 years, have you flown in an aircraft as a pilot or crew member or do you expect to fly in an aircraft as a pilot or crew member? If yes, complete the applicable sections in <i>Underwriting questionnaires</i> , NN9434E.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. In the past 10 years, have you participated in a hazardous sport such as scuba or skin diving, skydiving, hang gliding, ballooning or ultralight, mountain climbing, heli-skiing, back-country skiing or snowboarding/snowmobiling or racing of any kind or do you expect to participate in a hazardous sport? If yes, complete the applicable sections in <i>Underwriting questionnaires</i> , NN9434E.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
For disability policies only			
e. Have you ever received or requested a pension, disability benefits, compensation or been off work for more than 10 days, for any accident or sickness? If yes, provide details.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
f. If a licence or permit is required to operate your business, has it ever been suspended or revoked or has a regulating agency ever initiated a complaint against you? If yes, provide details.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
g. Have you ever declared personal or corporate bankruptcy? If yes, when was it discharged?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Person to be insured	Question	Details
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child:		



5.6 Employment information

▶▶ **Do not complete this section for any person to be insured who is applying for a change to their disability insurance only. Instead complete section 11.1 *Employment history*.**

Person "A" to be insured

What is your occupation?	
Employer's name	Employer's telephone number ()
Employer's address	

Person "B" to be insured

What is your occupation?	
Employer's name	Employer's telephone number ()
Employer's address	



5.7 Financial information

▶▶ **Do not complete this section for any person to be insured who is applying for a change to their disability insurance only. Instead complete section 11.2 *Financial information*.**

	Person "A" to be insured	Person "B" to be insured
a. What is your annual earned income (within \$10,000), including salary, commissions, bonuses and pension?	\$	\$
b. What is your annual income (within \$10,000) from other sources, including dividends, interest and income from real estate?	\$	\$
c. If income is not generated from any of the above sources, tell us the household income.	\$	\$
d. What is your personal net worth?	\$	\$
e. In the past five years, have the people to be insured or the business had any major financial difficulties, such as having pay garnished or going bankrupt?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide details, including the bankruptcy discharge date, if applicable.	

▶▶ **If you are not adding or increasing insurance, if you are only applying for a change to non-smoker, or if you are applying for a change from Healthstyle 5 to Healthstyle 4 or Healthstyle 3, you do not need to complete the rest of section 5. Go to section 6.**

Section 5 – Personal information (continued)

5.8 Business insurance over \$1,000,000

▶▶ Complete this section only if you are applying for business insurance over \$1,000,000. Otherwise, go to section 5.9.

▶▶ Do not complete this section for any person to be insured who is applying for a change to their disability insurance. Instead complete section 11.2 *Financial information*.

	This year	Last year
a. What is the book value of the business (net worth)?	\$	\$
b. What is the fair market value of the business?	\$	\$
c. What is the gross annual revenue?	\$	\$
d. What is the net annual after-tax income?	\$	\$
e. What is the percentage of the business owned by Person "A" to be insured?		%
What is the percentage of the business owned by Person "B" to be insured?		%
f. Are other partners, owners and executives being insured? <input type="checkbox"/> No <input type="checkbox"/> Yes If no, provide details, including why not.		

5.9 Individual life insurance for a child

▶▶ Complete this section only if you are applying to insure a child (17 years or younger) with an individual life insurance coverage (rather than a child rider). Otherwise, go to section 5.10.

	Parent 1 (living with child)	Parent 2 (living with child)
a. What is the total amount of life insurance in effect on each of the child's parents?	\$	\$
b. What is the gross earned income of each of the child's parents?	\$	\$
c. How many siblings does the child have?		
d. How much insurance is in effect on each sibling?	\$	\$

5.10 Over 70 and applying for insurance over \$250,000




▶▶ Complete this section only if you are older than 70 and you are applying for insurance over \$250,000.

Assets		Liabilities	
Value of primary residence	\$	Mortgage	\$
Registered investments	\$	Other liabilities	\$
Other investments and holdings	\$		

Section 6 – Height and weight

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider. All people to be insured must complete this section.

	Height	Weight	Has your weight changed by more than 10 pounds (4.5 kg) in the past 12 months? If yes, provide details, including the amount your weight changed and the reason. If the change resulted from pregnancy, tell us your pre-pregnancy weight.
Person "A" to be insured	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes
Person "B" to be insured	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes

	Height	Weight	Has the child lost more than five pounds in the past 12 months? If yes, provide details, including the amount the child's weight changed and the reason.
 Name of child under child rider:	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes
 Name of child under child rider:	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes
 Name of child under child rider:	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes

Section 7 – Medical information

In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider. All people to be insured must complete this section.

If you are providing medical information about the children to be insured, it is important that you have enough contact with the child to answer those questions reliably.

▶▶ If your advisor will have medical information collected by a paramedical service, complete sections 7.1 and 7.2, then go to section 8.



7.1 Your family medical history

a. Have either of your parents or a sibling been diagnosed before age 65 with any of the following conditions: heart disease, stroke or cancer?

Person "A" to be insured: No Yes unknown ▶ If yes, provide details in the chart below.

Person "B" to be insured: No Yes unknown ▶ If yes, provide details in the chart below.

Children under a child rider: No Yes unknown ▶ If yes, provide details in the chart below.

b. Have either of your parents or a sibling ever been diagnosed with Huntington's chorea, polycystic kidney disease, Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, high blood pressure, kidney disorders, retinitis pigmentosa or any hereditary disease?

Person "A" to be insured: No Yes unknown ▶ If yes, provide details in the chart below.

Person "B" to be insured: No Yes unknown ▶ If yes, provide details in the chart below.

Children under a child rider: No Yes unknown ▶ If yes, provide details in the chart below.

Person to be insured	Relative's relationship to you	Condition or impairment (if cancer, provide details, including the type and location)	Age at onset
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" Name of child:			
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" Name of child:			
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" Name of child:			



7.2 About your doctor or clinic

Do you have a family doctor or clinic that you use regularly?

No Yes If yes, provide the details.

Person "A" to be insured OR child under a child rider

Name of child under child rider

Person "B" to be insured OR child under a child rider

Name of child under child rider

Name of your doctor (first, middle initial, last) or clinic		
Address		
City or town	Province	Telephone number ()
Date last consulted (dd/mmm/yyyy)	Reason last consulted:	
Name on file with doctor or clinic (if different than current last name)		
Treatment or medication prescribed and results of any tests completed*		

Name of your doctor (first, middle initial, last) or clinic		
Address		
City or town	Province	Telephone number ()
Date last consulted (dd/mmm/yyyy)	Reason last consulted:	
Name on file with doctor or clinic (if different than current last name)		
Treatment or medication prescribed and results of any tests completed*		

*If you need additional space to describe your treatment, medications or information about your doctor or clinic for person "A", person "B" or a child under a child rider, add these details in section 7.5.


7.3 Your medical history

If you answer yes to any question in section 7.3, tell us the details in section 7.5.

a. Do you have, have you been treated for, or have you been told you have any of the following conditions?


	Person "A" to be insured	Person "B" to be insured	Children under a child rider
1. High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. High cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Cancer, tumours, leukemia, polyps or skin lesions	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Diabetes (including gestational diabetes and impaired glucose tolerance)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Section 7 – Medical information (continued)


b. Have you ever had or been told you had or been investigated or treated for conditions involving any of the following:	Person "A" to be insured	Person "B" to be insured	 Children under a child rider
1. Your heart and blood vessels , such as: <ul style="list-style-type: none"> • angina • blood clots • bypass or angioplasty • heart disease • cerebrovascular disease (CVA) • chest pain or shortness of breath • claudication • heart attack (myocardial infarction) • heart murmur • pacemaker • palpitations or irregular pulse • peripheral vascular disease or peripheral artery disease • poor circulation • stroke or transient ischemic attack (TIA) • swollen ankles other <input style="width: 100px;" type="text"/> 	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

For the tests related to these conditions, provide details.

<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child:	What test(s) did you have?	Why did you have the test(s)?
Result:		Date (dd/mmm/yyyy)
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child:	What test(s) did you have?	Why did you have the test(s)?
Result:		Date (dd/mmm/yyyy)


c. Have you ever had or been told you had or been investigated or treated for conditions involving any of the following:	Person "A" to be insured	Person "B" to be insured	 Children under a child rider
1. Your nose, throat or lungs , such as: <ul style="list-style-type: none"> • asthma • chronic obstructive pulmonary disease (COPD) • chronic or recurrent bronchitis • cystic fibrosis • emphysema • sarcoidosis • sleep apnea • tuberculosis other <input style="width: 100px;" type="text"/> 	1. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Your abdominal organs , such as: <ul style="list-style-type: none"> • cirrhosis • colitis • Crohn's disease • diverticulitis • gastrointestinal bleeding • hepatitis (including active or carrier state) • jaundice • irritable bowel syndrome • liver disease • pancreatitis • ulcer other <input style="width: 100px;" type="text"/> 	2. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Your kidneys, bladder or genital organs , such as: <ul style="list-style-type: none"> • abnormal pap smear • kidney stone • nephritis • uterine fibroids • prostatitis or other prostate disorder • protein in the urine or urinary tract infection (UTI) • polycystic kidney disease • tumour • sugar or blood in the urine • other kidney or bladder disorders • other reproductive disorder or sexually transmitted disease other <input style="width: 100px;" type="text"/> 	3. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Your breasts , such as: <ul style="list-style-type: none"> • abnormal mammogram findings or biopsy • cysts • lumps • other physical changes other <input style="width: 100px;" type="text"/> 	4. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Your nervous system , such as: <ul style="list-style-type: none"> • ALS or other motor neuron disease • Alzheimer's disease • cerebral palsy • cognitive impairment • coma • dementia • dizziness • Down syndrome • epilepsy • fainting or syncope • loss of speech • migraine headaches • multiple sclerosis • mental impairment or retardation • paralysis • Parkinson's disease • seizures or convulsions • tremor • vertigo other <input style="width: 100px;" type="text"/> 	5. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Your eyes or ears , such as: <ul style="list-style-type: none"> • blindness • blurred or double vision • deafness • glaucoma • impaired hearing • impaired sight • labyrinthitis • optic neuritis • tinnitus other <input style="width: 100px;" type="text"/> 	6. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Your mental health , such as: <ul style="list-style-type: none"> • anxiety • attempted suicide • burnout • depression • schizophrenia • other psychological, behavioral, emotional or eating disorder other <input style="width: 100px;" type="text"/> 	7. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
8. Your glands or blood , such as: <ul style="list-style-type: none"> • abnormal blood sugar • anemia • bleeding tendency • gout • hemophilia • lymph gland disorders • thyroid disorders • other endocrine disorders other <input style="width: 100px;" type="text"/> 	8. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
9. Your muscles or bones , such as: <ul style="list-style-type: none"> • any injury or disorder of the muscles, bones, joints or spine • chronic fatigue • chronic pain syndrome • fibromyalgia • muscular dystrophy • rheumatoid arthritis or osteoarthritis other <input style="width: 100px;" type="text"/> 	9. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
10. Your connective tissue , such as: <ul style="list-style-type: none"> • lupus • scleroderma other <input style="width: 100px;" type="text"/> 	10. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Section 7 – Medical information (continued)

	Person "A" to be insured	Person "B" to be insured	 Children under a child rider
11. Your skin , such as: <ul style="list-style-type: none"> • basal cell carcinoma • dysplastic nevus syndrome • dysplastic nevus 	11. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<ul style="list-style-type: none"> • lesions, freckles or moles that have changed in size, colour or have bled • psoriasis • dermatitis • nevus or nevi <input style="width: 100px; height: 20px;" type="text" value="other"/>			
12. Your immune system , such as: <ul style="list-style-type: none"> • HIV • AIDS 	12. <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<ul style="list-style-type: none"> • any generalized enlargement of your lymph glands • any test results indicating possible exposure to the HIV or AIDS virus <input style="width: 100px; height: 20px;" type="text" value="other"/>			
d. Has anyone ever recommended that you be tested for exposure to the HIV or AIDS virus (other than routine testing for insurance)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Do you have any reason to believe that you have been exposed to the HIV or AIDS virus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
f. In the past five years, have you:			
1. had any medical or diagnostic tests, such as ECGs, X-rays, CT scans, pap smear, MRI, or blood tests? If yes, provide details of the test results.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. had any illness or injury not already mentioned in this application?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. had any surgery, hospital care, treatment, medical examination, diagnostic test or counselling not already mentioned in this application or that has been recommended but is yet to take place?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. used any recommended medication (prescription or non-prescription) not already mentioned in this application?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. consulted a chiropractor, counselor or health care worker, physician or therapist?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
g. During the past 12 months, have you missed more than 15 consecutive days of work or school because of illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
h. Are you currently taking any prescribed medication, herbal or holistic treatment, or are you under observation for any condition other than those you have already told us about?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
i. Are you currently disabled and unable to perform your regular occupation or regular activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
j. Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
k. Are you pregnant? If yes, tell us your due date and the name and address of your obstetrician/gynecologist.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
1. What was your pre-pregnancy weight? <input style="width: 100px; height: 20px;" type="text"/> <input type="checkbox"/> lbs <input type="checkbox"/> kg			
2. Have there been any complications with your pregnancy? If yes, provide details.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
For disability policies only			
l. If you are a health care professional, have you been successfully vaccinated against hepatitis B? If yes, provide date. If no, please provide details.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
m. Have you ever had or been told you had or been investigated or treated for conditions involving your spine, back or neck , such as: <ul style="list-style-type: none"> • disc disease • pain • strain • sprain • sciatica <input style="width: 100px; height: 20px;" type="text" value="other"/> If yes, and the occurrence was within the past five years, complete section 11.4 Back pain questionnaire.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	



7.4 Children under age 2

If you answer yes to any question in section 7.4, tell us the details in section 7.5.





	Person "A" to be insured	Person "B" to be insured	 Children under a child rider
a. Has any child to be insured had surgery or been hospitalized for more than 3 days at birth or later?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
b. Was any child to be insured born prematurely (less than 36 weeks)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Were there difficulties surrounding the birth or in the post-partum term, congenital abnormalities, infectious disease or other health concerns?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

7.5 Medical information details

If you have answered yes to any of the questions in sections 7.3 or 7.4, tell us the details below. Include conditions, dates, durations, treatment, results and names and addresses of doctors, hospitals and clinics.

Person to be insured	Question	Details (If cancer, include type and location), treatment history, testing dates, reason for tests, results of tests, recurrence and names and addresses of all attending doctors.
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		

Section 7 – Medical information (continued)

Person to be insured	Question	Details (If cancer, include type and location), treatment history, testing dates, reason for tests, results of tests, recurrence and names and addresses of all attending doctors.
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B"  Name of child under child rider:		

Section 8 – Your other insurance policies







In this section, *you* and *your* refer to the people to be insured or the people insured by a disability waiver rider. If you are increasing or adding insurance to a policy, *you* and *your* can also refer to the people insured by or applying for a disability waiver rider.

▶▶ **Do not complete this section if you are applying for a change to your disability insurance only. Instead complete section 11.3 Your other disability insurance policies.**

a. Are any people to be insured currently covered under another life, critical illness, disability or long term care* policy, other than group insurance (including any policies that have lapsed within the past 90 days, any policies sold to a third party or any policies issued in another country)?

No Yes ▶ If yes, provide details.

* **For long term care policies:** Tell us the benefit amount and time period (for example, \$75/day or \$1,000/month).

Person to be insured	Name of insurance company	Policy number	Year issued	Amount & type of insurance (life, critical illness, disability or long term care)	Lapsed or sold to a third party?	Personal or business?	Replacing?	Replacement form completed?
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 				\$ Type:	<input type="checkbox"/> lapsed <input type="checkbox"/> sold to a third party	<input type="checkbox"/> personal <input type="checkbox"/> business	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 				\$ Type:	<input type="checkbox"/> lapsed <input type="checkbox"/> sold to a third party	<input type="checkbox"/> personal <input type="checkbox"/> business	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 				\$ Type:	<input type="checkbox"/> lapsed <input type="checkbox"/> sold to a third party	<input type="checkbox"/> personal <input type="checkbox"/> business	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 				\$ Type:	<input type="checkbox"/> lapsed <input type="checkbox"/> sold to a third party	<input type="checkbox"/> personal <input type="checkbox"/> business	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 				\$ Type:	<input type="checkbox"/> lapsed <input type="checkbox"/> sold to a third party	<input type="checkbox"/> personal <input type="checkbox"/> business	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 				\$ Type:	<input type="checkbox"/> lapsed <input type="checkbox"/> sold to a third party	<input type="checkbox"/> personal <input type="checkbox"/> business	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No




In all provinces, if this application for insurance is to replace an existing life insurance policy, complete and attach the required replacement disclosure forms.

In Quebec only, if this application for insurance is to replace an existing critical illness insurance policy, complete and attach the required replacement disclosure forms.

You must also complete all necessary forms to cancel the existing policy.

b. Have you applied for any other life, critical illness, disability or long term care insurance that has not yet been issued?

No Yes ▶ If yes, provide details.

Person to be insured	Name of insurance company	Reference number	Amount & type of insurance (life, critical illness, disability or long term care)	Personal or business?
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 			\$ Type:	<input type="checkbox"/> personal <input type="checkbox"/> business
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 			\$ Type:	<input type="checkbox"/> personal <input type="checkbox"/> business
<input type="checkbox"/> Person "A" <input type="checkbox"/> Person "B" <input type="checkbox"/> Child under a rider: 			\$ Type:	<input type="checkbox"/> personal <input type="checkbox"/> business

Section 9 – Information about your new policy

▶▶ **Complete this section only if you are converting term insurance, exercising a GIO or BVP, or cancelling a joint last-to-die UltraVision policy and issuing a new current-dated single life policy(ies).**

In this section, *Policy 1* refers to the policy that contains the term insurance or child rider to be converted, the guaranteed insurability option (GIO) or the business value protector (BVP) option or the joint last-to-die UltraVision policy to be cancelled. *Policy 2* refers to the policy that will contain the *new insurance* after it is converted, purchased through an option or issued.

Policy 2 may be a new policy or an existing policy. In some cases Policy 1 and Policy 2 may be the same policy.

We, us and our refer to The Manufacturers Life Insurance Company.

You and your refer to the owner of Policy 1, except where otherwise specified.

9.1 Policy ownership for the new policy

▶▶ **Complete this section only if the new insurance will be issued on a new policy.**

If you do not complete this section, the owner of the new policy will be the existing owner of Policy 1.

! If you are converting to a Performax Gold or universal life policy, tell us your social insurance number in the box provided.

a. Who will own the new policy?

- same as owner of Policy 1, **OR** same as Person "A" to be insured in section 3, **OR**
- same as Person "B" to be insured in section 3 **OR**
- provided below

Name of owner #1 of new policy (first, middle initial, last) or full name of legal entity such as company or trust (including Company, Limited, Inc., etc.)			
Social insurance number or business number		Relationship to person to be insured	
Address (number, street and apt.)		City or town	Province
			Postal code
Name of owner #2 of new policy (first, middle initial, last) or full name of legal entity such as company or trust (including Company, Limited, Inc., etc.)			
Social insurance number or business number		Relationship to person to be insured	
Address (number, street and apt.)		City or town	Province
			Postal code

9.2 Primary owner

▶▶ **Complete this section if there is more than one owner on the new policy.**

All correspondence about the insurance you are applying for will be addressed and mailed to the primary owner.

a. If there is more than one owner on your policy, tell us who the primary owner should be. For policies owned by a legal entity such as a company or trust, tell us the company department that should receive all correspondence (Example: Accounts payable).

- Owner of Policy 1 Person "A" to be insured Person "B" to be insured
- Owner #1 Owner #2

b. Preferred mailing address for the primary owner (if different than the address already provided).

Provide the preferred mailing address of the primary owner if it is different than the address already provided in this application. The preferred mailing address cannot be your advisor's address.

Address (street and number)		City or town	Province	Postal code

9.3 Multiple owners

a. Multiple owners (all provinces except Quebec)

If this policy is to be owned by more than one person, we will set it up as *joint ownership with right of survivorship*. This means policy ownership is shared between the joint policy owners and, if the policy is still in effect after the death of one of the joint owners, that owner's share automatically passes to the surviving joint owner or owners.

If you want ownership of your policy to be set up as *tenants in common* instead of *joint ownership with right of survivorship*, select *tenants in common* below.

- tenants in common (If you choose this ownership type, complete *Establishing tenants in common ownership for a policy*, NN0967E.)

b. Multiple owners (in Quebec)

If this policy is to be owned by more than one person, and if the policy is still in effect after the death of one of the owners, that owner's interest will pass to their estate unless a subrogated policy owner has been named for that person's interest in the policy.

Section 9 – Information about your new policy (continued)

9.4 Naming a successor or subrogated owner

a. Successor owner (all provinces except Quebec)

If there is only one owner and the policy may continue after the owner's death, identifying another person to take over ownership results in a faster and easier transfer.

Name of successor owner (first, middle initial, last)	Relationship to owner
---	-----------------------

b. Subrogated owner (in Quebec)

If the policy may continue after any policy owner's death, identifying another person to take over ownership results in a faster and easier transfer.

Name of subrogated owner for owner #1 (first, middle initial, last)	Relationship of subrogated owner to owner #1
Name of subrogated owner for owner #2 (first, middle initial, last)	Relationship of subrogated owner to owner #2

9.5 Billing information for the new policy

▶▶ If you are adding insurance to an existing policy, you do not need to complete this section. Your billing information for the existing policy will not change.

a. Your first payment

1. What is the amount of your first payment?

Amount \$

2. How is the first payment being made?

If you are paying by cheque, the cheque must be in Canadian funds drawn on a Canadian bank or financial institution and made payable to Manulife Financial. We do **not** accept cash.

- by cheque with this application (The cheque must be dated with the same date as this application.)
- use premium refund from Policy 1
- with funds from a policy insured by a Manulife Financial company (The Manufacturers Life Insurance Company, MFC Insurance Company or Manulife Canada Ltd.) as follows:

Take the payment from the policy as

- dividends a loan part of the policy's cash value (up to 50% of cash value)

Policy number	Name of person (first, middle initial, last) insured under the policy	Amount you are transferring \$
---------------	---	-----------------------------------

By signing below you agree that:

- you are entitled to receive the proceeds of the policy you've identified above
- the policy is insured by a Manulife Financial company, and
- you direct that company to withdraw the amount of money identified above and transfer it to the company that will insure the policy you are applying for in this application.

If the policy owner is a corporation, we require the signatures and titles of two corporate signing officers or the signature and title of one signing officer and the corporate seal. If the corporation does not have a corporate seal and you are the only person authorized to sign on behalf of the corporation, sign in the box for owner of the policy from which the funds are transferred and write your initials in the box provided.

Signature of owner of the policy from which the funds are transferred X	Date (dd/mmm/yyyy)
Signature of owner of the policy from which the funds are transferred X	Date (dd/mmm/yyyy)
Initial here Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.	
Signature of collateral assignee/hypothecary creditor (if applicable) X	Date (dd/mmm/yyyy)
Signature of irrevocable beneficiary (if applicable) X	Date (dd/mmm/yyyy)

Section 9 – Information about your new policy (continued)

b. Your regular payments

1. How will your regular payments be made?

If you are paying by cheque, the cheque must be in Canadian funds drawn on a Canadian bank or financial institution and made payable to Manulife Financial. We do **not** accept cash.

If the information you provide here is different than the information you provide in the product page for the product you are applying for, we will use the information in the product page.

- annually by cheque
 semi-annually by cheque
 quarterly by cheque
 monthly by automatic withdrawal using the banking information in section 9.6

Your monthly payment \$	Extra payment amount \$	Your total monthly payment \$
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For universal life or Performax Gold policies only

calculate the minimum payment **OR**
 the total planned deposit or additional payment is \$

c. Who will be making your payments?

you or

Name (first, middle initial, last or full name of legal entity, including Company, Limited, Inc. etc.)		Relationship to policy owner	
Address (street and number)	City or town	Province	Postal code
Name (first, middle initial, last or full name of legal entity, including Company, Limited, Inc. etc.)		Relationship to policy owner	
Address (street and number)	City or town	Province	Postal code

9.6 Banking information

In this section *you* and *your* refer to the owner(s) of the bank account from which withdrawals will be made.

▶▶ **Complete this section if you are making the regular payments by automatic monthly withdrawal.**

a. Automatic monthly withdrawal details

- add the automatic monthly withdrawals to an **existing** automatic monthly withdrawal plan with us
OR
 set up a **new** automatic monthly withdrawal plan using the banking information below

Policy number on which the current automatic monthly withdrawal plan is set up

Withdrawal date for automatic monthly withdrawals (1st through 28th)

What banking information should we use?

- from the cheque used to make the first payment
 from the attached void cheque (Attach the cheque to this page, immediately below. You can cover both the image and the following table.)
 as follows: (Only complete the table below if you do not have a void cheque)

The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.

Name of Canadian bank or financial institution	Transit number	Institution number	Account number
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Section 9 – Information about your new policy (continued)

9.7 Authorizing withdrawals from your bank account

In this section *you* and *your* refer to the owner(s) of the bank account from which withdrawals will be made.

The person who is making the payments must sign in section 12. Their signature in section 12 means that they have read and agree to the authorizations here.

By asking us to take one or more payments from your bank account, you agree that you have read and agree to the following information:

Authorization for variable amount automatic monthly withdrawals to make your regular payments

If you have asked us to establish an automatic monthly withdrawal plan to make your regular payments, you agree to the following:

- you authorize us to make monthly withdrawals from your bank account to pay for the policy
- except as otherwise stated in this agreement, the withdrawals will occur on the date that you specified above
- the withdrawals from your bank account are in variable amounts. In certain circumstances, we may increase these withdrawals to administer your policy. (Example: if the premiums for the policy are scheduled to change.) If you have a policy with insufficient account value to cover the monthly deduction, we will not increase the payments withdrawn from your bank account to prevent your policy from terminating, and
- **you waive the right to receive 10 days' notice of the amount and date of each automatic monthly withdrawal to be made from your account.**

What we will do if your bank or financial institution does not honour an automatic monthly withdrawal

If your bank or financial institution does not honour an automatic monthly withdrawal the first time we present it for payment, we may attempt to withdraw that payment again within 30 days.

If that withdrawal is not honoured, we may attempt to withdraw that amount again together with your next month's automatic monthly withdrawal.

We reserve the right to end the automatic monthly withdrawal plan immediately if a withdrawal is not honoured.

Making changes to your automatic monthly withdrawal plan

You can request changes to the amount of the automatic monthly withdrawal or the account from which the automatic monthly withdrawal is being taken by telephone or in writing. We must receive the request at least three days before the automatic monthly withdrawal date. The advisor for this policy can also make these changes on your behalf.

Universal life or Performax Gold policies

For universal life or Performax Gold policies, we have the right to change your monthly withdrawal date to be at least four days before your policy processing day.

Personal withdrawals

All automatic monthly withdrawals from your bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H1 at www.cdnpay.ca.

Cancelling this agreement

You or we can end this agreement at any time by giving 10 days' written notice, counted from the date the notice is mailed. For a sample cancellation form or more information about cancelling an automatic monthly withdrawal plan, contact your bank or financial institution or visit www.cdnpay.ca.

Unauthorized withdrawals

You have certain recourse rights if any withdrawal does not comply with this agreement. For example, you have the right to receive reimbursement for any withdrawal that is not authorized or is not consistent with this agreement. To obtain more information on your recourse rights, contact your bank or financial institution or visit www.cdnpay.ca.

Your personal information

You authorize us to collect, use, release and exchange any personal information necessary to fulfill any obligations relating to withdrawals made from your bank account.

For more information about withdrawals from your bank account

If you have any questions or concerns about withdrawals from your bank account, contact us using the contact information on page 36 of this application, in the section titled *How we resolve complaints*.

For more information about your rights, contact your bank or financial institution or the Canadian Payments Association at www.cdnpay.ca.

Certification

You certify that all people whose signatures are required on this account have signed in section 12, including any required joint account owners or corporate signing officers.

9.8 Acknowledgment and consent

In this section *you* and *your* mean the people to be insured, the owner(s) of Policy 1 and Policy 2, the parent or guardian (tutor, in Quebec) of any children to be insured who are under age 16 (under age 18 in Quebec) and any collateral assignee, hypothecary creditor or irrevocable beneficiary.

The *original insurer* refers to the company that issued or insures Policy 1.

By signing in section 12 of this form, you consent to the conversion of insurance or the exercise of the option or rider as described in this application, and:

- you authorize the original insurer to release all information connected with Policy 1 to us and applicable reinsurers and authorize us to use it as described in section 12,
- you agree that if we issue new insurance under the terms of this application, the effective date of the new insurance will be shown in Policy 2,
- you agree that the new insurance that comes into effect as a result of this application satisfies the original insurer's obligation to provide additional insurance under the original policy; the original insurer is released from this obligation to the same extent that the original insurer would have been released if they had provided the new insurance,
- you acknowledge that on the effective date of the new insurance, the coverage you are converting and any coverage you ask us to cancel will be cancelled; depending on the amount of insurance you are converting and cancelling, this may mean that Policy 1 will terminate,
- if you are converting insurance, purchasing insurance under a child rider, exercising a GIO or BVP option or cancelling a joint last-to-die UltraVision policy and issuing new single life policy(ies), you acknowledge that the time limits for contestability and suicide run from the later of the date the new insurance is issued or last reinstated,
- if you are a collateral assignee (hypothecary creditor, in Quebec), you acknowledge that we will not be bound with respect to Policy 2 until we receive a copy of the new assignment or hypothec of Policy 2 at our head office,
- if you are an irrevocable beneficiary, you acknowledge that your rights under Policy 1 will only be carried forward into Policy 2 if you are designated as an irrevocable beneficiary in Policy 2,
- if you own Policy 1 but not Policy 2, you acknowledge that you do not gain any ownership rights in Policy 2 as a result of this conversion or exercise,
- if the owner of Policy 2 is different than the owner of Policy 1, and Policy 2 is a Performax Gold or universal life policy, you acknowledge that any accumulated additional payment or deposit room in Policy 1 does not carry forward to Policy 2.



Sign in Section 12.

Section 10 – Temporary life and critical illness insurance questions

►► Complete this section if you have chosen one of the following options in section 1 and you want to apply for temporary life or temporary critical illness insurance on the person to be insured:

- Add a coverage
- Add a new insured person
- Add a new child rider
- Increase amount of insurance

In this section, *you* and *your* refer to the people to be insured.

Temporary insurance can apply to an individual life.

10.1 Eligibility for temporary life insurance

►► Do not complete this section if you are applying for a change to an UltraVision policy. Temporary life insurance is not offered with UltraVision.

Only people from the ages of 15 days to 75 years inclusive are eligible for temporary life insurance.

Each person to be insured under the policy who is applying for temporary life insurance must answer the following questions.

	Person "A" to be insured	Person "B" to be insured
a. In the past 12 months, have you consulted a doctor or other health practitioner for, been treated for or had any indication of heart attack, cancer, stroke or AIDS or HIV infection?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
b. In the past 60 days, have you consulted a doctor or other health practitioner and been told to have a further examination, diagnostic test or surgery which has not been performed, or for which the results are not known (other than pregnancy or childbirth)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

If a person to be insured answers *yes* to either question a or b above, that person is **not** eligible for temporary life insurance.

If a person to be insured answers *no* to questions a and b above, and if the conditions described on the *Temporary life insurance certificate* are met, temporary life insurance coverage for that person begins as soon as we receive payment.

The *Temporary life insurance certificate* on pages 24 and 25 explains your coverage.

10.2 Eligibility for temporary critical illness insurance

►► Do not complete this section if you are applying for a change to a Synergy solution. Temporary critical illness insurance is not offered with Synergy.

Only people from the ages of 18 years to 60 years inclusive are eligible for temporary critical illness insurance.

Each person to be insured under the policy who is applying for temporary critical illness insurance must answer the following questions.

	Person "A" to be insured	Person "B" to be insured
a. Do you have, or have you ever consulted a doctor or other health practitioner for, been treated for or had any indication of heart or blood vessel disease, heart attack, chest pain, diabetes, cancer or tumours, transient ischemic attacks, stroke or chronic kidney, liver or lung disease, multiple sclerosis, paralysis, blindness, deafness, loss of speech, loss of limbs, coma, dementia, cognitive impairment, Alzheimer's disease, Parkinson's disease, severe burns, AIDS or HIV infection?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
b. In the past two years, have you been refused coverage for life, critical illness, disability or long term care insurance or been offered insurance with restricted benefits or at higher than standard rates?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. In the past 60 days, have you been admitted or advised to be admitted to a hospital or clinic, other than for pregnancy or childbirth?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. In the past 60 days, have you consulted a doctor or other health practitioner and been told to have a further examination, diagnostic test or surgery which has not been performed, or for which the results are not known (other than pregnancy or childbirth)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

If a person to be insured answers *yes* to any of questions a – d above, that person is **not** eligible for temporary critical illness insurance.

If a person to be insured answers *no* to questions a – d above, and if the conditions described on the *Temporary critical illness insurance certificate* are met, temporary critical illness insurance coverage for that person begins as soon as we receive payment.

The *Temporary critical illness insurance certificate* on pages 24 and 25 explains your coverage.

10.3 Instructions for the advisor

! Leave any unused temporary insurance certificate attached to this application.

If **any** of the people to be insured are eligible for temporary insurance (that is, meet **all** the conditions on the applicable temporary insurance certificates on the following pages):

- accept payment for the full amount of the first premium on the policy
- give the policy owner the applicable certificate and the receipt for payment
- tell the policy owner that temporary insurance begins immediately for the people to be insured that are eligible as soon as we receive payment and if all the applicable conditions are met.

Otherwise,

- do not accept payment.

Manulife Financial Temporary life insurance certificate

In this certificate:

- *we, us* and *our* mean the companies as defined in section 1 of this application
- *you* and *your* mean the policy owner
- *insured person* means a person listed in section 3 of this application as a person to be insured or a child to be insured under a child rider
- *this application* means the *Application for change* with the same number that appears in the top right corner of this page and
- *this agreement* means this temporary life insurance certificate.

Conditions

If you are applying for a change to an UltraVision policy, temporary life insurance is not offered. Subject to the terms and conditions of this agreement, we agree to provide temporary life insurance coverage on each insured person who meets the following requirements:

- the insured person, except any child who is only to be insured under a child rider, answered *no* to questions a) and b) in section 10.1 and
- the age of the insured person is from 15 days to 75 years inclusive.

This agreement will take effect if the following conditions are satisfied:

- you complete and sign this *Application for change*
- you pay your first premium when this application is completed
- the payment we receive for the additional coverage applied for is enough to pay for that coverage until the next premium due date. It is not necessary to make a payment:

- if the policy being changed is a universal life policy, and
- if the payment we received for your existing policy is enough to also pay for the additional coverage applied for until the next premium due date
- the bank or financial institution honours the cheque when we first present it for payment and
- no information has been misrepresented or left out of this application, including information about children to be insured under a child rider, that would affect our decision to provide insurance or the terms under which we provide it.

No person may change this certificate in any way.

Temporary life insurance

1. The temporary life insurance coverage for an insured person will be in the same amount (subject to the maximum amount specified below) and of the same type (single life, joint first-to-die or joint last-to-die) as that applied for under this *Application for change* with respect to that insured person.
2. The terms of this temporary life insurance agreement do not apply if you have applied for any of the following:
 - reinstatement of a lapsed policy
 - insurance through a "portability" or "conversion" provision of an existing policy
 - insurance through a "purchase of new policy" or "conversion" option of a supplemental benefit or rider, including a "survivor's benefit".

In these cases, the terms of the provision, benefit or rider apply.

 **Detach and leave with the policy owner**

continued on the back

Manulife Financial Temporary critical illness insurance certificate

In this certificate:

- *we, us* and *our* mean the Manufacturers Life Insurance Company
- *you* and *your* mean the policy owner
- *insured person* means a person listed in section 2 of this application as a person to be insured, and does not include children to be insured under a child rider
- *this application* means the *Application for change* with the same number that appears in the top right corner of this page
- *this agreement* means this temporary critical illness insurance certificate
- *covered condition* means a condition as defined in the **Covered conditions** section of the standard policy contract
- *definite diagnosis* means the written statement by a specialist, supported by the appropriate investigation and medical evidence, that the insured person meets the definition of a covered condition in the standard policy contract
- *specialist* means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered condition for the benefit that is being claimed, and who has been certified by a specialty examining board. If a specialist is not available, and if we approve, a condition may be diagnosed by a qualified medical practitioner practising in Canada or the United States. Examples of specialists are included in the standard policy contract. The specialist must not be the policy owner, the insured person or a relative or business associate of the owner or the insured person.
- *satisfy* or *satisfies* means that the insured person must be living and meets all the requirements in the policy for the benefit they are claiming. *Additional information on the meaning of this word can be found in the standard policy contract.*
- *standard policy contract* means the standard policy contract offered by us for sale on the date of this *Application for change*, for the type of critical illness insurance applied for on this *Application for change*. You can obtain the standard policy contract from your advisor or at www.manulife.ca/b4ubuy.

Conditions

If you are applying for a change to a Synergy solution, temporary critical illness insurance is not offered.

Subject to the terms and conditions of this agreement, we agree to provide temporary critical illness insurance coverage on each insured person who meets the following requirements:

- the insured person answered *no* to questions a), b), c) and d) in section 10.2 and
- the age of the insured person is from 18 years to 60 years inclusive.

This agreement will take effect if the following requirements are satisfied:

- you complete and sign this *Application for change*
- The payment we receive when this *Application for change* is completed for the additional coverage must be enough to pay for the additional coverage applied for until the next premium due date
- the bank or financial institution honours the cheque when we first present it for payment and
- no information has been misrepresented or left out of this *Application for change*, including information about children to be insured under a child rider, that would affect our decision to provide insurance or the terms under which we provide it.

No person may change this certificate in any way.

Temporary critical illness insurance

The temporary critical illness insurance under this agreement covers all of the covered conditions included in the coverage you applied for, as defined in the **Covered conditions** section of the standard policy contract, except for the covered conditions specifically excluded in **Exclusions and limitations**, below.

1. We will pay a benefit to you on the occurrence of a covered condition if:
 - the definite diagnosis of the covered condition occurs while this agreement is in effect
 - the terms of this agreement are met

continued on the back

Temporary life insurance certificate (continued)

3. If you have applied to change joint last-to-die coverage on the insured person, no benefit will be paid with respect to the death of that insured person unless all people insured under that joint last-to-die coverage die while this agreement is in effect.
4. The combined maximum benefit payable for any insured person under all temporary life and critical illness insurance agreements with us is the amount of insurance, including accidental death benefits, applied for on that insured person or \$1,000,000, whichever is less.
5. With respect to the maximum benefit payable for an insured person, the benefit payable under any temporary critical illness insurance agreement will take precedence over any benefit payable under this agreement.
6. If the total amount of life insurance you've applied for on an insured person is greater than the maximum allowable under this agreement and that insured person dies while covered under this agreement, we will refund the portion of any premium you've paid for coverage for that insured person over their allowable maximum.
7. The beneficiary under this agreement will be the beneficiary named for that insured person in this *Application for change*.
8. The temporary life insurance outlined in this agreement will end on the earliest of:
 - the date we deliver a contractual document as a result of this *Application for change*
 - the date we mail you a notice that we have declined your *Application for change*
9. If we issue a life insurance policy to you based on the terms of this *Application for change*, we will apply your first premium payment to the premiums due under the policy. If we decline your *Application for change*, or if we offer you a policy based on terms other than those outlined in your *Application for change* and you do not accept the policy, we will refund your first premium payment.
10. Insurance that provides coverage over the maximum allowable, including any accidental death benefit, takes effect:
 - when we deliver the contractual document to you, and
 - when you have paid the new amount sufficient to provide coverage under the changed policy to the next premium due date, and
 - if the health or insurability of the people to be insured under the policy has not worsened between the time this *Application for change* was completed and delivery of the contractual document.

Exclusions and Limitations

If an insured person commits suicide, whether sane or insane, we will not pay a death benefit for that insured person. We will refund the premium you paid for life insurance coverage for that insured person and all coverage for that insured person under this agreement will end.



Temporary critical illness insurance certificate (continued)

1. The insured person satisfies all the criteria for the diagnosed covered condition and
 - the insured person has satisfied the waiting period for the diagnosed covered condition as defined in the standard policy contract.
2. The amount of the benefit payable under this agreement is the amount of Lifecheque coverage you have applied for on the insured person, subject to:
 - the maximum benefit amounts established by this agreement and
 - any other exclusions and limitations in this agreement.
3. The maximum benefit for any insured person under all temporary critical illness insurance agreements with us is the total amount of critical illness insurance coverage applied for on that insured person or \$500,000, whichever is less.
4. The combined maximum benefit for any insured person under all life and critical illness temporary insurance agreements with us is the amount of insurance applied for on that person, including accidental death benefits, or \$1,000,000, whichever is less.
5. In determining the maximum benefit payable for an insured person, the benefit payable under this agreement will take precedence over any benefit payable under a temporary life insurance agreement.
6. If we pay a benefit to you under this agreement, we will refund any premium collected for insurance coverage that exceeds our maximum benefit payable under this agreement for that insured person.
7. Temporary critical illness insurance coverage on the insured person ends on the earliest of:
 - the date we deliver a contractual document as a result of this *Application for change*
 - the date we mail you a notice that we have declined your application for critical illness insurance
8. If we issue a critical illness policy to you based on the terms of this *Application for change*, we will apply your first premium payment to the premiums due under the policy. If we decline your application, or if we offer you a contractual document based on terms other than those outlined in your *Application for change* and you do not accept the contractual document, we will refund your first premium payment.

Exclusions and limitations

No LivingCare benefit, early intervention benefit or recovery benefit is payable under this agreement.

The exclusions and limitations described throughout the standard policy contract apply.

No payment will be made under this agreement for the covered conditions cancer and benign brain tumour, as defined in the standard policy contract.

Section 11 – Information required for disability policies

In this section, *you* and *your* refer to the person to be insured.

- ▶▶ Complete this section if you are applying for a change to a disability insurance policy.
- ▶▶ Do not complete if you are applying for a change to a Synergy solution.

11.1 Employment history

- a. Occupation
- b. Professional designation/Degree
- c. How many years have you worked in this occupation?
- If less than two years, tell us your former occupation
- d. Name and address of employer (if you are an employee)
- Name and address of business (if you are self-employed)
- e. What is the nature of the business?
- f. If you are self-employed: No. of partners/principals No. of full-time employees No. of part-time employees
- g. How many years/months have you been with this employer or been self-employed?
- h. Do you work at home? No Yes If yes, provide details:
1. Number of hours you work: Daily or Weekly
2. Is your office open to the public? No Yes
3. Do you have any employees other than family members working in your home? No Yes
- i. How many hours do you work per week?
- j. Is your employment year-round? Yes No If no, indicate which months you work.
- k. Job duties – Describe your job duties and indicate the percentage of time spent performing each duty:

Job duties	Percentage of time spent	Description of duties
1. Manual/Physical	%	
2. Administration/Office	%	
3. Sales	%	
4. Supervision	%	
Location: Office (including Executive/Professional)	%	
Shop/Plant	%	
On site	%	

- l. Are you aware of any changes that will occur within the next 12 months that will change your duties or employment status?

No Yes If yes, provide details.

- m. Do you have any part-time employment? No Yes If yes, tell us:

Occupation Annual net income \$

Duties

Section 11 – Information required for disability policies (continued)

Section 11.2 – Financial information

a. What is your **current employment status**? Select all that apply.

Your T1 is your income tax and benefit return filed with the Canada Revenue Agency for the most recent year.

- Employee (if you declared income on your T1, lines 101 and 104)
- Commissioned sales (if you declared income on your T1, lines 101 plus 104 minus line 229)
- Sole proprietor (if you declared income on your T1, lines 135-143)

Fiscal year-end (dd/mmm)

- Partner (if your net income is declared on your T1, lines 135-143)

Percentage of ownership	%	Fiscal year-end (dd/mmm)
-------------------------	---	--------------------------
- Incorporated (if your net income is declared on your T1, lines 101 and 104 **plus** your share of the corporate profits or losses)

Percentage of ownership	%	Fiscal year-end (dd/mmm)
-------------------------	---	--------------------------

b. What was your **Insurable Net Annual Earned Income for last year and for two years ago**? Include income from all sources identified above.

Insurable Net Annual Earned Income: your net annual earned income after allowable business expenses are deducted, but before taxes, as declared to Canada Revenue Agency

Last year

Year

 \$

 Two years ago

Year

 \$

c. If you are self-employed, do you split your income for tax purposes? No Yes If yes, tell us the amount on your spouse's T4.

Last year

Year

 \$

 Two years ago

Year

 \$

Attach a copy of your spouse's T4, with their authorization for our collection, use and retention of this information.

d. Do you expect that your **Insurable Net Annual Earned Income for this year will be at least 80% of last year's income**?

- No Yes ▶ If no, provide details.

--

e. Have you changed your employment status(es) in the past 12 months? No Yes If yes, provide details.

--

Unearned Income: income that is **not** dependent upon your ability to work; for example, investment income, rental income, royalties, pension or similar income

f. Calculate your **Unearned Income for last year and estimate it for this year. Do either of those figures exceed the lesser of \$30,000 or 15% of your Insurable Net Annual Earned Income**? No Yes If yes, provide details.

	Current year <table border="1" style="display: inline-table; width: 50px;"></table>	Prior year <table border="1" style="display: inline-table; width: 50px;"></table>
Dividends	\$	\$
Interest	\$	\$
Pension	\$	\$
Capital gains	\$	\$
Net rental	\$	\$
Other	\$	\$
Total	\$	\$

Net worth: the value of your assets minus your liabilities

g. Does your net worth exceed \$4,000,000? No Yes If yes, provide details.

Assets		Liabilities	
Residence	\$	Residence mortgage	\$
Other real estate	\$	Other mortgages	\$
Personal property	\$	Bank loans	\$
Equity in business or practice	\$	Other	\$
Cash, stocks, bonds	\$	Total	\$
Other	\$		
Total	\$	Total assets minus total liabilities = Total Net Worth	\$

Section 11 – Information required for disability policies (continued)

Section 11.3 – Your other disability insurance policies

- a. Are you eligible for employment insurance? No Yes
- b. Are you eligible for workers' compensation? No Yes
- c. Do you have any other disability insurance in effect or pending? No Yes If yes, complete the chart below.

Include individual, group, association, creditor insurance, salary continuation, accident only, overhead expense or disability buy-sell or any other type of insurance which provides disability benefits issued or pending in any country.

Name of insurance company	Pending		Issue date (mmm/yyyy)	Monthly benefit amount	Elimination period	Benefit period	Buy-Sell	Over-head	Taxable benefits		Is insurance being replaced?	
	Yes	No							Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>		\$			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		\$			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		\$			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		\$			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In Quebec only, if this application for insurance is to replace an existing disability insurance policy, complete and attach the required replacement disclosure forms.

You must also complete all necessary forms to cancel the existing policy.

Section 11.4 – Back pain questionnaire

▶▶ Complete this section if you are applying for a change to a disability insurance policy and you answered yes to section 7.3 question m.

- a. Have you ever experienced pain or discomfort in your back? No Yes
- b. What area of the back was involved? neck (cervical) middle (thoracic) low (lumbar)
- c. What was this pain caused by? disc problem muscular problem bone(s) problem

d. What was the date your first episode occurred?

1. How long did the symptoms persist?

2. Were you off work? No Yes If yes, provide details, including length of time off work.

e. Have there been any recurrences? No Yes

1. Tell us the dates and duration of each recurrence

2. Were you off work? No Yes If yes, provide details, including length of time off work.

f. When did you last experience back pain or discomfort?

g. What treatment and/or tests including X-rays have you undergone?

(Include dates and duration and exact tests, results and/or treatment given.)

h. Names and addresses of health professionals consulted

Indicate: medical doctor chiropractor other (specify): _____

Section 11 – Information required for disability policies (continued)

i. Do you have any limitation or restriction of back movement? No Yes If yes, provide details.

1. Does the limitation or restriction of back movement limit your ability to perform your work? No Yes If yes, provide details.

Section 11.5 – Overhead expenses

▶▶ Complete this section if you are applying for a change to ExpenseComp policies.

a. How many people share the expenses?

b. What proportion of the expenses do you pay?

Note: If there are more than four partners, include a copy of the expense-sharing agreement.

c. What is the total number of employees?

1. Tell us the position and the number of employees in each position (Example: Reception: 2; Accounting clerk: 1; etc.)

Position and number of people in that position	Position and number of people in that position
Position and number of people in that position	Position and number of people in that position
Position and number of people in that position	Position and number of people in that position

d. What are the average monthly expenses incurred in the operation of the office?

Do **not** include expenses incurred for:

- the purpose of acquiring goods for sale, supplies or additions to inventory;
- salaries, fees, drawing account or remuneration for: the person to be insured, any member of the person to be insured's profession or related profession, any person sharing the business expenses of the person to be insured;
- travel and/or entertainment.

Expenses

Your share

Expenses	Your share
1. a. Rent or	
b. Property taxes and mortgage interest payments plus depreciation or principal payments	
2. Office maintenance	
3. Public utilities (heat, water, electricity)	
4. Telephone, postage, paging, fax, and answering service	
5. Employee salaries and benefits (except as above)	
6. Management company fee (excluding family owned firm)	
7. Accounting services	
8. Professional association membership fees	
9. Property and liability insurance premiums	
10. a. Leased equipment or	
b. Interest payments plus the greater of scheduled depreciation or principal payments for equipment	
11. Interest plus principal payments for business loans from a financial institution to purchase business	
12. Other fixed monthly expenses (normal and customary):	
a.	
b.	
Total	

Section 12 – Authorizations, agreements and signatures

In this section, *you* and *your* mean the people to be insured, the policy owner, the parent or guardian (tutor, in Quebec) of any children to be insured who are under age 16 (under age 18 in Quebec) and any new policy owner of Policy 2.

Read this entire section carefully. It explains how your personal information is used to issue and administer the insurance policy you have applied for.

At the end of the section we ask you to sign. Your signature means that you authorize and agree to the ways we collect, use, share and retain your personal information and that you agree to the terms described in this application. You may not alter any of the wording in section 12. Any attempt to do so will be of no effect. If you wish to withdraw your consent or opt out of direct marketing, see the relevant section below.

Your personal information is important

We understand that the privacy of your personal information is important to you and we assure you that it's equally important to us. Personal information is fundamental to our business as it allows us to evaluate, issue and administer the policy you have applied for.

Collecting your personal information

In addition to the personal information you provide in this application, we may need to:

- request any test that may be necessary for us to decide if and on what terms to insure you, such as a medical examination, X-ray or blood test
- obtain from any doctor, medical practitioner, hospital, medically related facility, insurance company or other organization, person or source that has any information or records of you, your financial situation or your health, any information that we and applicable reinsurers require to issue or administer the insurance policy you have applied for
- obtain your personal information from the Medical Information Bureau, as explained in the notice that we have provided to you
- obtain a copy of all driving-related information from the Motor Vehicle Division in any province that is relevant to this application
- obtain a personal investigation, credit bureau report and/or a consumer report.

We may appoint an agent to collect your personal information on our behalf.

Dealing with us by telephone

Customer service calls are recorded for service quality control, information verification and training.

Using your personal information

We may use the personal information that we collect to:

- confirm your identity and to uniquely identify you
- confirm the accuracy of the information collected
- understand your financial situation better, evaluate your application, assess the insurance risks we are assuming and review claims submitted to us
- properly administer any financial services and products we provide
- comply with legal and regulatory requirements
- conduct searches to locate you and update your contact information in our files and

- determine whether other financial products offered by us, our affiliates and select financial product providers, are suitable for you so that we can provide you with details on those products.

In addition, we may use your social insurance number and your business number (if applicable) to uniquely identify you and to fulfill our tax-reporting requirements.

Sharing your personal information

We may share your personal information with the following people, organizations or service providers:

- our corporate affiliates, employees and agents who require this information to perform their jobs
- third-party service providers who require this information to provide their services to us, which may include:
 - paramedical agencies
 - underwriters
 - claims investigators and investigative agencies
 - providers of information processing and storage, programming, printing, mailing and distribution services
- your advisor and any agency that employs your advisor or has named your advisor as its agent, and their employees
- the Medical Information Bureau, as explained in the notice that we have provided to you
- applicable reinsurance companies to allow them to evaluate and administer any insurance risk that they accept
- people to whom you have granted access
- people who are legally authorized to view your personal information.

These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. Your information may be shared as required by the laws of those jurisdictions.

Section 12 – Authorizations, agreements and signatures (continued)

There are other situations where we may share aspects of your personal information with others, as described below.

- We may share medical information collected about you with your doctor.
- We may share your personal information with an organization or person from whom we are collecting information about you, but only as required to obtain the information we need.
- If laboratory tests performed on our behalf show that you have tested positive for infectious diseases such as HIV or hepatitis, we may report this information to the appropriate public health authorities, as required.

The personal information you provided in this application:

- will become part of the printed contracts that result from this application, and
- will be shared with all the owners and any subsequent owners of those printed contracts, even if you are not the owner or one of the people to be insured for that printed contract.

Protecting and retaining your personal information

We protect the personal information that we collect and secure it in an individual insurance file. We will keep your personal information for the longer of:

- the time period required by law and by guidelines set for the financial services industry
- the time period required to administer the products and services we provide.

In the event that your application is declined, the authorizations, agreements and consent that you provide throughout this application continue in effect.

Withdrawing consent

You may withdraw your consent for us to collect, use, share or retain your personal information if federal or provincial laws give you this right.

If you have withdrawn your consent or if your consent is not adequate, you agree that until adequate consent is given the following consequences may apply:

- a policy will not be issued if you withdraw your consent before the policy is issued
- no benefit will be payable under the policy
- you or your estate will not be able to exercise any rights you have under the policy without our agreement and
- at our option, we may choose to terminate the policy.

You may at any time withdraw your consent for us to use your social insurance number and your business number for the purpose of uniquely identifying you. However, withdrawal of this consent may affect our ability to ensure the accuracy of your personal and financial information.

To withdraw your consent, you must use the form and the process for withdrawal of consent that we determine.

Contact us for detailed information or for forms by calling our customer service centre at:

1-888-626-8543 in all provinces except Quebec, or
1-888-626-8843 in Quebec, or

by writing to the privacy office at the address on page 36.

Opting out of direct marketing

You have the right to opt out of additional product offerings. By withdrawing your consent for us to use your personal information for the purpose of marketing, you understand it will not affect our ability to continue to provide you with the products and services you have requested, but it will exclude you from receiving direct personalized marketing or special offers on other products and services.

Contact us to opt out of direct marketing by calling our customer service centre at:

1-888-626-8543 in all provinces except Quebec, or
1-888-626-8843 in Quebec.

If your policy or any rider that provides a death benefit contains a suicide provision

You agree that the amount payable on the death of an insured person who commits suicide will be determined as follows:

- If the suicide of an insured person occurs **within the time period** stipulated in the suicide provision, we will pay the amount described in that provision.
- If the suicide of an insured person occurs **after the time period** stipulated in the suicide provision, but within two years of the issue date of
 - an increase in the amount of insurance for that person on the policy or on a rider or
 - the addition of a rider relating to that insured person if that rider provides a death benefit,

we will pay the amount described in the death benefit provision as if the increase or addition had not occurred. We will also return any premium amounts paid, or cost of insurance deducted, for that increase or addition.

Section 12 – Authorizations, agreements and signatures (continued)

Terms for issuing policy changes

A policy change takes effect when

- any payment due to us as a result of the change has been paid and
- the change is approved by us at our head office provided there has been no change in the insurability of the insured person or people since the application was completed.

This application includes the pages numbered 1 to 36 plus all written statements submitted in connection with it.

By signing on page 33 or 34, you agree that:

- You ask us to make changes/additions to Policy 1 as shown in section 1 of this application. You authorize us to amend the policy or issue a replacement policy if necessary.
- We can void any change within two years after the change is made if a person to be insured or policy owner states a material fact incorrectly or fraudulently, misrepresents or fails to disclose any fact which would have affected our decision to allow the change or the premium to be charged after the change, whether the misrepresentation or lack of disclosure occurs in:
 - the *Application for change*; or
 - any medical evidence form; or
 - any written statement or answers provided as evidence of insurability.

If an insured person dies during those two years, we can contest at any time. We can also contest at any time with respect to a misstatement of age, a total disability benefit, or fraud.

- When you take delivery of the changed policy or any document endorsing the change you have requested, you agree to its terms, including any changes we have made to the terms.
- You understand that the authorizations you provide will remain in effect after the policy owner and the people to be insured die so we can evaluate and review any claim under the policy.
- If the premium or cost of insurance for this policy increases as a result of this application for change, the owners of the bank account from which withdrawals will be made authorize us to increase the monthly withdrawal to cover the amount of the cost increase. They waive the right to receive 10 days written notice of such an increase.
- For universal life or Performax Gold policies, we have the right to change your monthly withdrawal date to be at least four days before your policy year date.

- For reinstatements, if the premiums or payments for the policy are paid by automatic monthly withdrawal, and
 - the policy lapsed within the past three months, we will resume the automatic monthly withdrawal plan. The owner(s) of the bank account from which withdrawals will be made **must sign in section 12** to authorize us to increase the monthly withdrawal by the new amount required to keep the policy in effect as a result of this policy change or reinstatement.
 - the policy lapsed more than three months ago, the payor must complete *Request to change or create a new automatic monthly withdrawal plan*, NN0312E to confirm the automatic withdrawal plan details for the reinstated policy.

Section 12 – Authorizations, agreements and signatures (continued)

Signatures for Policy 1

Review this application, including the authorizations and agreements on pages 30, 31, and 32 and sign below.

By signing below you are confirming that:

- you have read the application and confirm that the statements in it are complete, current and accurate to the best of your knowledge and belief. You will immediately notify us of any errors or omissions
- if you have completed section 9 for a term conversion, to exercise a GIO or BVP option or to cancel a joint last-to-die UltraVision policy and issue a new current-dated single life policy(ies), you acknowledge and consent to the terms in section 9
- if this application results in a new policy, you have read and understood the final version of the policy illustration (if one is required), including the fact that some values may not be guaranteed; you will contact us immediately if you have any concerns regarding your illustration
- if you are eligible for temporary insurance, you have read and understood the *Temporary life insurance certificate* and/or the *Temporary critical illness insurance certificate* (see pages 24 and 25) and you understand that the temporary insurance applies only to those people to be insured who meet all of the conditions for eligibility, regardless of the amount of premium paid with this application
- you agree to the terms and conditions described in this application
- a copy of this authorization and agreement is as valid as the original document

Note: If the policy owner is a corporation, we require the signatures and titles of two signing officers or the signature and title of one signing officer and the corporate seal. **If the corporation does not have a corporate seal and you are the only person authorized to sign on behalf of the corporation, sign in the box for owner of Policy 1 and write your initials in the box provided.**

Signed at (city or town, province)		Date (dd/mmm/yyyy – for example, 23/JUL/2011)*		* If all required signatures are obtained on the same date, write that date here only.
Signature of Person "A" to be insured X	Signature of witness X	Date (dd/mmm/yyyy)		
Signature of Person "B" to be insured X	Signature of witness X	Date (dd/mmm/yyyy)		
Signature of child to be insured if age 16 or over (outside Quebec) X	Signature of witness X	Date (dd/mmm/yyyy)		
Signature of owner of Policy 1 (if not Person A or B) X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)	
Signature of owner of Policy 1 (if not Person A or B) X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)	
For corporations: Full legal name (including Company, Limited, Inc., etc.)				
Initial here	Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.			
Signature of witness X	Name of witness (if not advisor)			
Signature of collateral assignee/hypothecary creditor of Policy 1 X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)	
Signature of collateral assignee/hypothecary creditor of Policy 1 X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)	
Signature of irrevocable beneficiary of Policy 1 (if applicable) X	Signature of witness X			

If a person to be insured is under age 16 (under age 18 in Quebec), the mother, father or guardian/tutor (if they are not also a policy owner) must sign below to consent to this application for insurance.

Relationship to the person to be insured: mother father guardian/tutor

Signature of parent or guardian/tutor X	Signature of witness X
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Signatures continue on the next page.

Section 12 – Authorizations, agreements and signatures (continued)

Your advisor's access to your personal information

Do you authorize Manulife Financial to share the following information with your advisor if that information affects your application:

- our findings concerning your blood pressure, cholesterol level or physical build, and
- any information provided in this application, or in any telephone interview or paramedical interview?

Person "A" to be insured Yes No Person "B" to be insured Yes No

If you do not answer this question, we will share this information with your advisor. Your advisor may use this information to discuss your insurance options with you.

Signatures for Policy 2

See section 9 for a description of Policy 2.

Signature of owner of Policy 2 (if not an owner of Policy 1) X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)
Signature of owner of Policy 2 (if not an owner of Policy 1) X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)
For corporations: Full legal name (including Company, Limited, Inc., etc.)			
Initial here	Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.		
Signature of collateral assignee/hypothecary creditor for Policy 2 (if Policy 2 is an existing policy) X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)
Signature of collateral assignee/hypothecary creditor for Policy 2 (if Policy 2 is an existing policy) X	Title (if signing for a corporation)	Signature of witness X	Date (dd/mmm/yyyy)
Signature of irrevocable beneficiary for Policy 2 (if applicable) X		Signature of witness X	Date (dd/mmm/yyyy)

Authorizing monthly withdrawals

- ▶▶ **Do not sign below if you are an insured person or owner of Policy 1 or Policy 2.**
- ▶▶ **Sign below if you are the owner(s) of the bank account from which automatic withdrawals will be made and you are not an insured person or an owner of Policy 1 or Policy 2 and:**
 - you are asking us to establish an automatic monthly withdrawal plan or
 - the automatic monthly withdrawals for this policy are increasing as a result of the policy change requested or
 - the automatic monthly withdrawals for this policy are resuming as a result of the reinstatement requested.
- If withdrawals are to be made from a joint account and your bank or financial institution requires both signatures, both account owners must sign.
- If withdrawals are to be made from a corporate account, identify the corporate account and provide the signatures and titles of two corporate signing officers or the signature and title of one signing officer and the corporate seal. **If the corporation does not have a corporate seal and you are the only person authorized to sign on behalf of the corporation, sign in the box for account owner #1 and write your initials in the box provided.**

Name of account owner #1 or corporate signing officer #1 (if not a person to be insured or the policy owner)	Relationship to policy owner
Signature of account owner #1 X	Title (if applicable)
For corporations: Full legal name (including Company, Limited, Inc., etc.)	
Initial here	Write your initials here to confirm that you are the only person authorized to sign on behalf of the corporation and that it does not have a seal. You must also sign above.
Name of account owner #2 or corporate signing officer #2 (if not a person to be insured or the policy owner)	Relationship to policy owner
Signature of account owner #2 X	Title (if applicable)

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Manulife Financial

Authorization to share information – Person A

You and your refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. Us and our refer to The Manufacturers Life Insurance Company (Manulife Financial). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, or of your children or their health (if applicable), to share or exchange information with us or applicable reinsurers.

Signed at (city or town)	Date (dd/mmm/yyyy)
Signature of Person "A" to be insured X	
Signature of witness X	

If the person to be insured is under age 18:

Relationship to the person to be insured:

mother father guardian (tutor, in Quebec)

Signature of parent or guardian/tutor X
Signature of witness X



Manulife Financial

Authorization to share information – Person B

You and your refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. Us and our refer to The Manufacturers Life Insurance Company (Manulife Financial). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, or of your children or their health (if applicable), to share or exchange information with us or applicable reinsurers.

Signed at (city or town)	Date (dd/mmm/yyyy)
Signature of Person "B" to be insured X	
Signature of witness X	

If the person to be insured is under age 18:

Relationship to the person to be insured:

mother father guardian (tutor, in Quebec)

Signature of parent or guardian/tutor X
Signature of witness X



Manulife Financial

Receipt for payment

Amount received \$

By signing below, the advisor confirms that this payment is for the insurance applied for in this application, covering the people listed below.

Name of Person "A" to be insured (first, middle initial, last)	Name of Person "B" to be insured (first, middle initial, last)
Total amount of insurance coverage applied for \$	Date (dd/mmm/yyyy)
Signature of advisor X	



Detach and leave with policy owner

Manulife Financial

Medical Information Bureau

We consider the information contained in your application to be confidential. However, Manulife Financial or reinsurers involved with your policy may make a report to the Medical Information Bureau based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made.

The Medical Information Bureau is a non-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, the Medical Information Bureau will share any information it has on file.

You may review the information in your file, and request a correction if necessary, by contacting the bureau at:

Medical Information Bureau
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

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Your right to access your personal information

You can ask to review your personal information in our files and have any inaccuracies corrected by sending a written request to:

Privacy office - Individual Insurance, 25 Water Street S.,
PO Box 800 Stn C, Kitchener, ON N2G 4Y5

How we resolve complaints

We're delighted that you are interested in purchasing an insurance product from us and we're committed to continually affirming your confidence in us in the years to come. If you have any concerns with the product or with the service you receive, you can rest assured that we will handle all of your questions and concerns fairly and efficiently.

To discuss any questions or concerns you may have, contact your advisor or our head office at:

1-888-626-8543 in all provinces except Quebec, or

1-888-626-8843 in Quebec

More information about our complaint resolution process is available on the Internet at www.manulife.ca under *Consumer Assistance*.

Where you can find more information about our privacy policy

To obtain a copy of our policies and practices for handling personal information, contact our privacy office at the address above, or visit www.manulife.ca > Privacy Policy.

Advisor's report

In this report, *you* and *your* refer to the advisor who is selling the insurance coverage.

1 Advisor information

a. List the advisors involved in this sale or policy change.

If the servicing advisor shown is not the original servicing advisor, we will update our records to use the servicing advisor shown here. Only the original advisor can submit applications for a plan exchange or change.

1. Name of servicing advisor (first, middle initial, last)			2. Name of advisor (first, middle initial, last)			3. Name of advisor (first, middle initial, last)		
Advisor code	Branch code	Percentage of commission %	Advisor code	Branch code	Percentage of commission %	Advisor code	Branch code	Percentage of commission %

2 About the people to be insured

a. How long have you known the people to be insured?

Person "A" to be insured	Person "B" to be insured
<input type="checkbox"/> years	<input type="checkbox"/> years
<input type="checkbox"/> months	<input type="checkbox"/> months

b. Which underwriting requirements have you requested for the people being insured? Select all that apply.

	Person "A" to be insured	Person "B" to be insured		Person "A" to be insured	Person "B" to be insured
Paramedical	<input type="checkbox"/>	<input type="checkbox"/>	Electro-cardiogram	<input type="checkbox"/>	<input type="checkbox"/>
Medical by physician	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>
Medical by internist or cardiologist	<input type="checkbox"/>	<input type="checkbox"/>	Treadmill stress test	<input type="checkbox"/>	<input type="checkbox"/>
Insurance blood profile	<input type="checkbox"/>	<input type="checkbox"/>	Inspection report	<input type="checkbox"/>	<input type="checkbox"/>
Height, weight, blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Micro-urinalysis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

c. Is/are the owner and person(s) to be insured fluent in the language of this application?

Owner No Yes
 Person "A" to be insured No Yes
 Person "B" to be insured No Yes

If *no*, tell us what language(s) the person(s) identified above are fluent in and describe the steps that were taken to ensure that they understood the questions and authorizations in this application.

d. Did you complete this application in person with the person(s) to be insured and the owner(s)?

No Yes

If *no*, provide details including how the application was completed and who completed the application.

3 General information

a. If the person to be insured qualifies for a Healthstyle that is better than the Healthstyle you illustrated, tell us what you want us to do.

- issue the policy with the amount of insurance illustrated (the premium will be lower than the premium illustrated)
- increase the amount of insurance to an amount that keeps the same premium illustrated and issue the policy with the improved Healthstyle (the amount of insurance will increase but the premium will remain the same as the premium illustrated)
- increase the amount of insurance to an amount that is within the age and amount requirements (the premium will increase and financial underwriting will be required before the new amount of insurance is approved)

b. Tell us any other information that may be useful in reviewing this application as well as any special policy date or other requests.

4 Advisor's certification

By signing below:

- you confirm that you hold all necessary licences and certificates to write this application for change for the area where the transaction occurred
- if this policy is replacing another policy, you confirm that you have made the proper disclosures to your client and have completed the appropriate replacement documents and, if necessary, you have provided these documents to us
- you confirm that you have disclosed the following information to the owner of this policy:
 - the name of the company or companies you represent
 - that you receive commissions for the sale of life and living benefits 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 ✕	Email address or telephone number for advisor