

# ASSOCIATION GROUP INSURANCE

COMPLETING AND RETURNING THIS APPLICATION FORM COULD BE THE BEST THING YOU'VE EVER DONE TO HELP SECURE YOUR FINANCIAL FUTURE AND THE FUTURE OF YOUR FAMILY. FOR THE AFFORDABLE PROTECTION THAT YOUR PROFESSIONAL ASSOCIATION GROUP PLAN CAN PROVIDE, PLEASE REPLY TODAY!

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

**WHEN APPLYING FOR COVERAGE, PLEASE COMPLETE ALL INFORMATION REQUESTED BELOW.**

## MEMBER INFORMATION

Name  First  Last  Male  Female

Unit/Apt. #  No./Street  City

Province  Postal Code  Tel. Res. (  )  Bus. (  )

E-mail†  Date of Birth  Day /  Month /  Year Country of Birth

Applicant is a member of:

OR (specify in what capacity, in relation to the above Association/Society you are applying)  Name of Association/Society

†Your e-mail address is important to us. At Manulife Financial we value your privacy. We do not sell or rent out our customer information. From time to time you may receive e-mails from us about new products and relevant information. Each time you receive an e-mail from us, you will have the option to opt out of our mailing list.

## SPOUSE INFORMATION (if applying for spouse coverage)

Name  First  Last  Male  Female

Date of Birth  Day /  Month /  Year Country of Birth  Occupation

## BENEFITS APPLIED FOR AT THIS TIME (Do not include units already in force)

New Coverage <input type="checkbox"/>	Additional Coverage <input type="checkbox"/>	Certificate # <input type="text"/>	(if currently insured)	<b>MONTHLY PREMIUM</b>
<b>Member Term Life Insurance</b> Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/>	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$ <input type="text"/>
Minimum – 2 Units				
10% rate reduction for volume purchase (if coverage is 8 or more units)	→ No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	X .9 = \$ <input type="text"/>
<b>Spouse Term Life Insurance</b> Standard <input type="checkbox"/> Non-Smoker* <input type="checkbox"/>	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$ <input type="text"/>
Available only if you participate in the Member Term Life Plan. Minimum – 2 Units				
10% rate reduction for volume purchase (if coverage is 8 or more units)	→ No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	X .9 = \$ <input type="text"/>
<b>Child Term Life Insurance</b>	No. of Children <input type="text"/>		Premium <b>\$2.25</b>	= \$ <input type="text"/>
Available only if you participate in the Member Term Life Plan. (One monthly premium covers all your eligible children for \$10,000 of life coverage each.)				
<b>Member Income Protection Insurance</b>	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$ <input type="text"/>
Waiting period <input type="text"/> days.				
<b>Office Overhead Expense Insurance</b>	No. of Units <input type="text"/>	X	Premium Per Unit <input type="text"/>	= \$ <input type="text"/>
Waiting period <input type="text"/> days.				
<b>Member Personal Accident Insurance</b>	No. of Units <input type="text"/>	X	Premium Per Unit <b>\$1.50</b>	= \$ <input type="text"/>
Available only if you participate in the Member Term Life Plan.				
<b>Spouse Personal Accident Insurance</b>	No. of Units <input type="text"/>	X	Premium Per Unit <b>\$1.50</b>	= \$ <input type="text"/>
Available only if you participate in the Spouse Term Life Plan.				
<b>*Non-Smoker rates apply to people who have not smoked cigarettes in the past 12 months and who meet Manulife Financial's health standards.</b>				
<b>TOTAL MONTHLY PREMIUM</b>				= \$ <input type="text"/>

**All Applicants:** This application is not valid unless the Underwriting Questionnaire section is properly completed and the application is signed.

**Québec Residents:** After completion, you may detach this section and send it directly to the insurance company in the enclosed business reply envelope.

## UNDERWRITING QUESTIONNAIRE - PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS

Member's Physician Name  Tel. #  Date last seen (D/M/Y)

Reason for Visit  Result

Spouse's Physician Name  Tel. #  Date last seen (D/M/Y)

Reason for Visit  Result

Member's Height  Weight  Spouse's Height  Weight

Has any individual proposed for coverage :	Member		Spouse		Child(ren)	
	YES	NO	YES	NO	YES	NO
1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including carrier state), kidney disorder, urinary abnormality, unusual infection or immune system abnormality, or other illness not mentioned?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been treated for or advised to reduce alcohol or drug use?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had back, neck, hip or knee trouble, been treated for chronic pain or fibromyalgia, had X-rays of spine or joints or been hospitalized or disabled by any injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

