Manulife

Personal Critical Illness

- **Application**
- **Evidence of Insurability**
  - **Complete only if applying for a total coverage amount over $25,000**
- **Payment Information**
- **Certification and Authorization**

Manulife

Group Benefits
Personal Critical Illness Application

Conditions for eligibility

By signing the Authorization section of this Application on page 10 of 11, I signify my understanding and acknowledgement that in order to qualify for coverage in amounts of $25,000 or less that do not require the completion of a detailed medical questionnaire, the person(s) whom I seek to insure under this application (myself, my spouse, my child(ren) or any one of us) must be in good health ("Good Health"), and accordingly, I **declare** that the person(s) whom I seek to insure is (are) in Good Health and more specifically, that any adult(s) to be insured does (do) not have any physical or mental conditions that prevent them:

(a) if they are employed, from regularly attending to their occupation, or

(b) if they are not employed, from being so employed if they chose to engage in an occupation; and

that the person(s) whom I seek to insure has (have) never been declined when they have either applied for or been the subject of any application for life insurance or critical illness insurance coverage with any insurer, or other entity. I also **understand and acknowledge** that where this application is approved by Manulife, the contract issued to me will contain an exclusion under which benefits will not be paid for any pre-existing medical conditions, as defined in the contract.

Instructions:

1. Please consult your plan administrator for the policy number and certificate number, if applicable.
2. Please print in ink.
3. **Please retain a photocopy for your files.**

1a) Plan member information

Required if applying for member, spousal or child coverage

Policy number(s)	Plan member certificate number	Plan sponsor/employer name
136376		The Boilermakers' National Health Fund (Canada)

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Sex*	Home phone number	Business phone number
◯ Male ◯ Female ◯ Non-binary	( )	( )

Plan member's address (number, street and apartment)	City

Province	Postal code	Email address

By providing my personal email address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.

* Select male, female or non-binary (intersex) consistent with your current biological sex. For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

1b) Personal critical illness amount

Required if applying for member coverage

Available in multiples of $5,000 with a minimum $10,000 up to $150,000.

Are you applying for the first time? ◯ Yes ◯ No

If *yes*, amount requested $_____

If *no*, additional amount requested $_____

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

2 Spousal information

Only required if applying for spousal coverage

Spouse's name (first, middle initial, last)	Sex*	Date of birth (dd/mmm/yyyy)
	◯ Male ◯ Female ◯ Non-binary	

Spousal life amount

Available in multiples of $5,000 with a minimum $10,000 up to $150,000.

Are you applying for the first time? ◯ Yes ◯ No

If *yes*, amount requested $_____

If *no*, additional amount requested $_____

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

* Select male, female or non-binary (intersex) consistent with your current biological sex. For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

3 Child information

Only required if applying for coverage for child(ren)

Child life amount:
◯ $10,000 benefit applies to all eligible dependent children under age 21.

Provide details for all children under age 21.

Name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)	Sex*
		◯ Male ◯ Female ◯ Non-binary
		◯ Male ◯ Female ◯ Non-binary
		◯ Male ◯ Female ◯ Non-binary
		◯ Male ◯ Female ◯ Non-binary

* Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Manulife

Group Benefits
Personal Critical Illness Evidence of Insurability

Complete only if applying for a total coverage amount over $25,000.

The following questions should be answered by each individual applying for coverage that needs to provide evidence of insurability as part of your application. If more space is needed, use another form or sheet of paper (both must be signed and dated).

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Policy number(s)	Plan member certificate number
136376	

Plan member name (first, middle initial, last)

Member ◯ Smoker ◯ Non-smoker Spouse ◯ Smoker ◯ Non-smoker

1 a) Plan member basic medical information

Only required if applying for total coverage over $100,000

Height _____ m _____ cm _____ ft _____ in

Weight ◯ kg ◯ lb

Any weight change greater than 4.5 kg/10 pounds in the last 12 months? ◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb

Reason: _____

Name of personal physician (first, middle initial, last)

Physician's phone number ( )

Date of last visit (dd/mmm/yyyy)

Reason

Address of personal physician (number, street and suite)

City | Province | Postal code

1 b) Spouse basic medical information

Only required if applying for total spousal coverage over $25,000

Height _____ m _____ cm _____ ft _____ in

Weight ◯ kg ◯ lb

Any weight change greater than 4.5 kg/10 pounds in the last 12 months? ◯ No ◯ Yes Gain/loss _____ ◯ kg ◯ lb

Reason: _____

Name of personal physician (first, middle initial, last)

Physician's phone number ( )

Date of last visit (dd/mmm/yyyy)

Reason

Address of personal physician (number, street and suite)

City | Province | Postal code

2 Medical questionnaire

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

	Plan member	Spouse
A. **Have you ever had an application for any insurance that was declined, postponed or rated in any way?** If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Reason

2 Medical questionnaire (continued)

	Plan member	Spouse
B. **Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment, care or been advised to receive care or have further treatment for:**		
1) AIDS, a positive HIV test or AIDS-related disease?	◯ Yes ◯ No	◯ Yes ◯ No
2) Diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
3) Multiple sclerosis?	◯ Yes ◯ No	◯ Yes ◯ No
4) Organ transplant?	◯ Yes ◯ No	◯ Yes ◯ No
5) Hepatitis or hepatitis carrier state, other than Hep A?	◯ Yes ◯ No	◯ Yes ◯ No
6) Stroke or transient ischemic attack (TIA)?	◯ Yes ◯ No	◯ Yes ◯ No
7) Alzheimer's disease or Parkinson's disease?	◯ Yes ◯ No	◯ Yes ◯ No
8) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?	◯ Yes ◯ No	◯ Yes ◯ No
9) Motor neuron diseases, including but not limited to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)?	◯ Yes ◯ No	◯ Yes ◯ No
10) Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congestive heart failure, arrhythmia, peripheral vascular disease, or aneurysm?	◯ Yes ◯ No	◯ Yes ◯ No
11) Paralysis? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Is it trauma related? ◯ Yes ◯ No	◯ Local or ◯ General paralysis
Details		

12) Chest pain? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Cause		
Diagnosis / Status		
Treatment		
13) Congenital heart disorder? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Cause		
Diagnosis / Status		
Treatment		
14) Heart murmur, shortness of breath, irregular heart beat, any disorder of the blood? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Cause		
Diagnosis / Status		
Treatment		
15) Lymph, glandular disorder, or thyroid disorder? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		

2 Medical questionnaire (continued)

	Plan member	Spouse
16) Disorder of the eye or ear leading to blindness or deafness? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
17) Alcohol or drug abuse? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) and duration		
Treatment and results		
18) Disorder of the brain or nervous system, neurological disorder, epilepsy, optic neuritis, blurred or double vision, memory loss, weakness, tremor, numbness or tingling, impaired balance, loss of consciousness? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date of onset (dd/mmm/yyyy) / Date of last symptoms (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
Name and address of doctor seen		
19) Cancer, leukemia, Hodgkin's disease or other malignancy?	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
20) Growths, cysts or tumour? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
21) Dysplastic nevi or moles? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy) / Type		
Location on body / Status ◯ Benign ◯ Malignant		
Treatment		
22) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs? If answered *yes,* please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date of onset (dd/mmm/yyyy) / Date of last symptoms (dd/mmm/yyyy)		
Diagnosis / Status		
Treatment		
Name and address of doctor seen		

2 Medical questionnaire (continued)

	Plan member	Spouse
C. 1) **Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, diabetes (2 or more family members prior to age 50), chronic kidney disease, angina, stroke, multiple sclerosis, Huntington's disease, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60?** If answered *yes*, please provide details in the chart below.	◯ Yes ◯ No	◯ Yes ◯ No

Plan member or spouse's family member	Relationship	Condition	Age at onset	Age at death (if applicable)
◯ Member ◯ Spouse				
◯ Member ◯ Spouse				
◯ Member ◯ Spouse				
◯ Member ◯ Spouse				

		Plan member	Spouse
2)	If you have a family history of breast or ovarian cancer, have you had a breast exam, mammogram or other investigation? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)
Results	

		Plan member	Spouse
3)	If you have a family history of colon cancer, have you had a colonoscopy? If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)
Results	

	Plan member	Spouse
D. **During the last 5 years, have you had any abnormal result of any of the following: EKG, stress EKG, echocardiograms, mammogram, Pap smear (exclude if 2 subsequent Pap smears have been normal), PSA, sigmoidoscopy, colonoscopy, biopsy?** If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Test type	Date (dd/mmm/yyyy)
Test results		Status
Treatment		

	Plan member	Spouse
E. **Other than for a common cold, osteoarthritis, bone fractures, have you had an abnormal result of any of the following: X-ray, CAT scan, or MRI?** If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Test type	Date (dd/mmm/yyyy)
Test results		Status

2 Medical questionnaire (continued)

	Plan member	Spouse
F. **Have you ever had elevated blood pressure or cholesterol?** If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person / Date (dd/mmm/yyyy)		
Most recent results / Is it under control?		
Treatment		
G. **Are you aware of any symptoms or complaints for which you have not sought treatment or advice, or are you awaiting any tests or test results?** If answered *yes*, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No
Name of person		
Details		

Manulife

Group Benefits
Personal Life Payment Information

Premium amount(s) are specified in your contract and may change over time. Please ensure funds are available in your account at the time of the application as your premium is due the 1st of the month following approval. If more than one month of premium is due that amount will be withdrawn from your account.

For Manulife use

Policy number(s): 136376

Certificate number

Plan member name (first, middle initial, last)

Monthly payment by pre-authorized debit (PAD)

For verification purposes we require a VOID cheque.

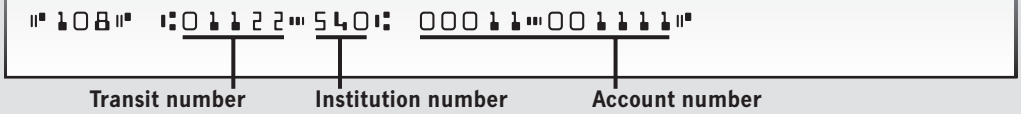
Select one of the following:

◯ Personal PAD ◯ Business PAD

Manulife Bank
500 KING ST. NORTH
WATERLOO, ONTARIO N2J 4C6

MEMO

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 account holder

Name of financial institution

Type of account ◯ Chequing ◯ Non-chequing

Transit number | Institution number | Account number

Joint accounts: Is this a joint account requiring only one signature? ◯ Yes ◯ No
If more than one signature is required on withdrawals issued against the account, both account holders must sign the authorization on page 10 of 11.

Non-chequing accounts: For accounts with no chequing privileges, Manulife requires validation from your financial institution (e.g. withdrawal slip with official stamp) in order to begin the pre-authorized payment process.

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Group Benefits
Personal Critical Illness Certification and Authorization

1 Certification and authorization

I certify that I, being the plan member with the capacity to contract, am applying for this personal benefits coverage/insurance ("Coverage") and that all information provided in support of this application is true and complete. I agree that my Coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in support of this application. **I authorize** Manulife to collect, use, maintain and disclose my personal information and personal health information including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, relevant to this application ("Information") for the purposes of the assessment, investigation and/or management of this application, including but not limited to medical underwriting; and where Coverage is issued, the administration, audit and management of my Coverage and the investigation of any claims made thereunder, including my participation in any independent medical assessments (collectively, the "Purposes"). **I understand** that I am responsible for any fees related to the completion of this application. Where this application pertains to one of my Dependents (spouse and/or child) **I certify that I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any such Dependants, for the Purposes. **I authorize** any person or organization with Information including, but not limited to, any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I hereby authorize** the use of my Social Insurance Number ("SIN"), where my SIN is used as my certificate number, for the purposes of identification and administration of this application and any Coverage, and for the facilitation of any pre-authorized collection.

I authorize Manulife to withdraw, until further written notice from me or my duly authorized representative, all premium payments ("Payments") due in relation to the Coverage from the bank account identified on the attached void cheque (referred to herein as the "Account") on or about the first business day of each month in which Coverage premiums are due. **I also understand and agree** that either Manulife or I may, at any time upon written notice, discontinue the direct withdrawal of Payment(s), from my Account, in which case Manulife shall be entitled to require another method of payment, acceptable to Manulife. The terms and conditions of this pre-authorized collection authorization shall apply to the Accounts herein named by me and any other Accounts I choose to name in the future, and shall remain valid for the duration of my Coverage or until revoked by me in writing. **I agree** that if I have asked Manulife to debit my bank account for a Pre-authorized Debit (PAD) plan (Personal or Business PAD), **I authorize** the bank or other financial institution I have named to honour my instructions. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. **I understand** that Manulife or I may terminate a PAD plan by giving 10 days written notice, beginning on the date the notice is mailed. **I understand** that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights or cancellation rights, I may contact Manulife, my financial institution or visit www.payments.ca for more information.

If applicable, **I authorize** Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not yet guaranteed as a secured means of communication.
I agree that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife.
I understand that if I do not wish to receive Information (or other materials related Manulife products and services) from Manulife through the email address identified on this form that I may contact the Customer Service Centre to opt-out of receiving this information.

I agree a photocopy or electronic version of this authorization is valid. **I acknowledge** that Manulife's Privacy Policy is available upon request or at www.manulife.ca

Signature of plan member	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if the Evidence of Insurability has been completed on behalf of the spouse)	Date signed (dd/mmm/yyyy)
Signature of account holder, if different from plan member	Date signed (dd/mmm/yyyy)
Signature of joint account holder (if applicable)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a personal benefits file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

PRINT

Please complete next page.

2 Mailing instructions

Please send the completed form and, if applicable, VOID cheque to:

Group Medical Underwriting
Manulife
PO BOX 1900, STATION C
KITCHENER ON N2G 4R4

Phone: 1-866-318-2727