Manulife

Personal Life

- **Application**
- **Evidence of Insurability**
  - **Complete only if applying for total plan member coverage over $100,000 and spousal coverage over $50,000.**
- **Payment Information**
- **Certification and Authorization**

Manulife

Group Benefits
Personal Life Application

Conditions for eligibility

By signing the Authorization section of this Application, I understand that for me to qualify for coverage up to $100,000 and for my spouse to qualify for coverage up to $50,000 without completing a detailed medical questionnaire, the person(s) whom I seek to insure under this application must be in good health.

I **declare** that the person(s) whom I seek to insure is (are) in good health and 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.

I **declare** 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 coverage with any insurer, or other entity.

I also **understand** that if this application is approved by Manulife, the contract will contain an exclusion under which benefits will not be paid for claims relating to any pre-existing conditions incurred during the first 24 months of coverage.

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.**

1 a) Plan member information

Required if applying for member, spousal or child coverage

*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.

Policy number(s): 136376

Plan member certificate number:

Plan sponsor/employer name: The Boilermakers' National Health Fund (Canada)

Plan member name (first, middle initial, last):

Sex* ◯ Male ◯ Female ◯ Non-binary

Date of birth (dd/mmm/yyyy):

Home phone number ( )

Business phone number ( )

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.

Email address:

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

City | Province | Postal code

1 b) Personal life amount

Required if applying for member coverage

Available in multiples of $25,000 up to $500,000.

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 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

NOTE: This section is to be used to identify beneficiaries for coverage on the plan member only. For spouse and/or dependant coverage, the plan member is automatically the beneficiary, if living, and if not living, the plan member's estate will be the beneficiary.

For designated beneficiaries under the age of majority.

Name of beneficiary (first, middle initial, last) (please print)	Relationship to plan member	Percentage of benefit
		%
		%
		%
	TOTAL	0

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

Irrevocability

For Quebec residents only

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

If spouse is beneficiary, designation is:

◯ Revocable ◯ Irrevocable

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

3 Spousal information

Only required if applying for spousal coverage

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

Spousal life amount
Available in multiples of $25,000 up to $500,000.

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.

4 Child information

Only required if applying for coverage for child(ren)

Child life amount:
◯ $20,000 benefit applies to all eligible dependent children under age 21.

Please provide the following information for each dependant to be insured.

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

Complete only if applying for total plan member coverage over $100,000 and spousal coverage over $50,000.

For Manulife use

Policy number(s): 136376

Plan member certificate number

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

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason

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

Address of personal physician (street number, street and suite)

City

Province

Postal code

Physician's phone number

1 b) Spouse basic medical information

Only required if applying for total spousal coverage over $50,000

Height _____ m _____ cm _____ ft _____ in

Weight ◯ kg ◯ lb

Have you lost or gained more than 4.5 kg/10 lbs during the last 12 months? ◯ Yes ◯ No If *yes*, please answer the following:

What was the amount of weight change? ◯ kg ◯ lb

Was this a gain or a loss?

Reason

Is name of personal physician the same as member? ◯ Yes ◯ No

If *no*, please provide:

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

Address of personal physician (street number, street and suite)

City

Province

Postal code

Physician's phone number

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.

Complete only if applying for total plan member coverage over $100,000 and spousal coverage over $50,000.
COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS.
If you require more room for YES answers please attach a separate sheet (signed and dated).

	Plan member	Spouse
1. During the past 12 months have you		
(a) flown as a pilot, student pilot or crew member or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	◯ Yes ◯ No	◯ Yes ◯ No
2. Have you		
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	◯ Yes ◯ No	◯ Yes ◯ No
(b) ever had an application for life or health insurance declined, postponed, or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No
(c) been absent from work for medical reasons during the last 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
(d) currently received any treatment/medications?	◯ Yes ◯ No	◯ Yes ◯ No
(e) In the past 60 days, have you consulted a doctor or other health practitioner, had medical testing done for anything other than pregnancy or minor ailments (e.g. sprains, cold or flu)?	◯ Yes ◯ No	◯ Yes ◯ No
(f) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	◯ Yes ◯ No	◯ Yes ◯ No

2 Medical questionnaire (continued)

	Plan member	Spouse
3. Have you ever consulted a physician, ever been treated for, or had any known identification of (a) Chest pain, blood vessel disease, heart disorder, heart attack, heart murmur, angina cardiac bypass surgery, stent placement or angioplasty, or stroke?	◯ Yes ◯ No	◯ Yes ◯ No
(b) high blood pressure?	◯ Yes ◯ No	◯ Yes ◯ No
(c) allergies or skin disorders, including growths, cysts or tumours?	◯ Yes ◯ No	◯ Yes ◯ No
(d) glandular disorders, including thyroid disorders and diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
(e) epilepsy, neurological disorder (e.g. Multiple Sclerosis, Parkinson's)?	◯ Yes ◯ No	◯ Yes ◯ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	◯ Yes ◯ No	◯ Yes ◯ No
(g) Have you ever been treated for, counselled, or advised to seek treatment for alcohol or drug abuse?	◯ Yes ◯ No	◯ Yes ◯ No
(h) In the past 12 months have you used or smoked cannabis or hashish?	◯ Yes ◯ No	◯ Yes ◯ No
(i) In the past 12 months have you smoked cigars? If *yes*, how many cigars have you smoked?	◯ Yes ◯ No	◯ Yes ◯ No
(j) lung disorders or shortness of breath?	◯ Yes ◯ No	◯ Yes ◯ No
(k) ulcer, colitis, bowel, stomach, reproductive organs or liver disorders?	◯ Yes ◯ No	◯ Yes ◯ No
(l) cancer?	◯ Yes ◯ No	◯ Yes ◯ No
(m) sexually transmitted disease, urinary tract infection, disorder of the kidney, blood, urine, or genital organs?	◯ Yes ◯ No	◯ Yes ◯ No
(n) arthritis, rheumatism or fibromyalgia?	◯ Yes ◯ No	◯ Yes ◯ No
(o) disorders of the muscles or bones including the back, spine or joints?	◯ Yes ◯ No	◯ Yes ◯ No
(p) immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	◯ Yes ◯ No	◯ Yes ◯ No
(q) anemia, or other blood disorders?	◯ Yes ◯ No	◯ Yes ◯ No
4. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	◯ Yes ◯ No	◯ Yes ◯ No

Please provide details below, if you have answered "Yes" to ANY questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

QUESTION NUMBER	NAME OF PERSON (FIRST & MIDDLE)	DETAILS OR NAME OF CONDITION	DATE AND DURATION	TREATMENT AND RESULTS (RECOVERY OR REMAINING EFFECTS)	NAMES AND ADDRESSES OF PHYSICIANS AND HOSPITALS

	Plan member	Spouse
5. 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
◯ Plan member ◯ Spouse			
◯ Plan member ◯ Spouse			
◯ Plan member ◯ Spouse			
◯ Plan member ◯ Spouse			

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:

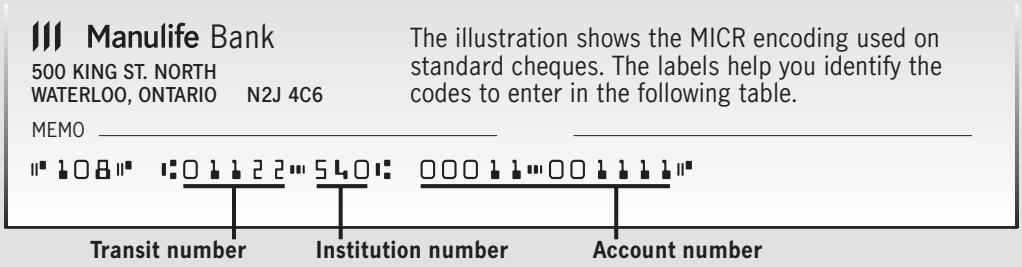
Plan member name (first, middle initial, last):

Monthly payment by pre-authorized debit (PAD)

For verification purposes we require a VOID cheque.

Select one of the following:

◯ Personal PAD ◯ Business PAD



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 7 of 8.

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.

Manulife

Group Benefits
Personal Life 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 designate** the person(s) named under the Beneficiary Designation section, above, as my beneficiary, in the event that the Coverage is issued. **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