Manulife

Second Signature if Joint Account ____

Account Holder Address _

Lifecheque® Basic Critical Illness

Advisor ID: 11804 001 WSFXL

Application Form	Ac	dvisor Name:	r Name:		
	Ac	dvisor E-mail:			
	_				
Applicant Inform	nation • Must be a	a Canadian resi	ident		
Please contact me at: Home Business E-mail					
Last Name	First Name			Initial	
Address					
City	Province		Postal Code		
Email					
Date of Birth (DD/MMM/YYYY)		☐ Female			
Home Telephone ()	Business Telep	hone ()		
Choi	ce of Coverage	e			
Please note that coverage is effective the first of the month fo			nt are received by I	Manulife.	
Amount of coverage applying for: \$25,000 \$\text{ With Return of Premium Option: (Available for ages 18 to 55) \$\text{ Confirm my smoking status as: }\text{ Smoker }\text{ Smoker } A non-smoker is defined as a person who has not used any tobacco, ni For Quebec Residents Only: Do you intend to replace any existing in with this insurance coverage? \$\text{ Your Application of The Normal States of The No	Non-Smoker* icotine substitutes, tobacco cess surance coverage (other than co	(Please selo (Please selo sation products or m	ect 🗸 one) ect 🗸 one) arijuana within the la:		
If "Yes", please do not cancel your existing coverage. A replacement form or dec	laration may be required. We may	not be able to issue an	insurance policy if replac	cement is indicated.	
Pav	ment Method				
Select one method of payment: CREDIT CARD AUTHO		ard Rilling Frequency	: Monthly	☐ Annually	
I/We hereby authorize Manulife to make a withdrawal from my/our accoundant Authorization may be terminated by either Manulife or by me/us through qualifying method should a withdrawal be refused for any reason and the will be charged for all NSF (Non-Sufficient Funds) transactions. Credit Card: Visa MasterCard American Express	written notice. Manulife may te	erminate coverage or	change the method of	payment to another	
Card Number		Expiry Date	(MM/Y	YYY)	
Name of Cardholder	Signature of Cardhold	der			
Second Signature if Joint Credit Card Account		Dated	(DD/MMM/Y	YYY)	
Pre-Authorized Debit (PAD) Payment Information & Payme	ent Authorization				
Please use the following banking information: From the attached void cheque (Attach a blank cheque marked "VOID")	Manulife Bank 500 KING ST. NORTH WATERLOO, ONTARIO N2J 4C6 MEMO	standard cheq codes to enter	n shows the MICR enc ues. The labels help y in the following table.	ou identify the	
OR	"108" 101122"51	<u> 40: 00011:00</u>	001111		
As follows: (only complete the table below if you do not have a void cheque)	Transit number In	 	Account number		
Transit Number Institution Number					
Financial Institution					
I/We authorize Manulife to withdraw premiums on or about the first busing may be for variable amounts and may change in accordance with the interpretation of the amount and date of each automatic with automatic monthly withdrawal the first time I/we present it for payment, the right to ask me/us for an alternate method of payment if my/our paybe treated as personal withdrawals as defined by the Canadian Payment 10 days' written notice. I/We understand that cancelling this PAD agreem Any refund of premium paid pursuant to this authorization shall be made.	surance contract and as require hdrawal from my/our accou Manulife may attempt to without moneyment is not honoured. All one-ts Association in Rule H-1. I/Wenent may result in loss of insurant	ed to administer the p unt. If my/our bank of draw that payment ag time or automatic w a and/or Manulife car	policy. I/We waive the or financial institution gain within 30 days. No inthropolic from my/on end this agreement as	ne right to receive does not honour ar Manulife may reserve ur bank account wil at any time by giving	
I/We may obtain a sample cancellation form by contacting my/our financ account, I/we can contact 1-800-590-0970, AM_service@manulife.com					
I/We have certain recourse rights if any debit does not comply with this a that is not authorized or is inconsistent with this PAD agreement. To obtain the financial institution or visit www.cdnpay.ca.	agreement. For example, I/we h	ave the right to receive	ve reimbursement for	any PAD withdrawa	
Name of Account Holder	Signature of	f Account Holder			

(DD/MMM/YYYY)

Dated ____

Declaration • Please read carefully before signing

Health Declaration

I declare that I have never been diagnosed with, had any signs and/or symptoms of, or had any medical consultations and/or abnormal tests for the following disorders:

- Cancer, Intracranial Tumour
- Heart Disease (including but not limited to Angina and Heart Attack), Stroke, Transient Ischemic Attack (TIA), Peripheral Vascular Disease or Diabetes
- Hepatitis, including Hepatitis Carrier State, Chronic Kidney Disease, AIDS or HIV

I declare that I have never had Coronary Artery Bypass surgery and/or Aortic surgery.

I declare that I have not undergone any medical or diagnostic tests for which I am currently awaiting results and I have not been advised by a doctor or specialist to undergo any medical or diagnostic tests which have not yet been completed.

I declare that during the past 5 years I have not had any signs and/or symptoms of, received treatment for, or been advised to seek treatment regarding Drug Abuse and/or Alcoholism.

General Declaration

I hereby apply for insurance to The Manufacturers Life Insurance Company.

I declare that the information contained in this application is true and complete and forms the basis of any Policy issued hereunder.

I declare that I am a Canadian resident between the ages of 18 and 65 years. I understand that my coverage will come into effect on the first day of the month following the date my application and payment are received by Manulife.

I acknowledge and declare that I have read and understand the information concerning the terms of coverage under the plan and the limitations and exclusions applicable to such coverage, including those related to pre-existing conditions.

I also declare that, if selecting a non-smoker benefit and premium option, I have not used any tobacco, nicotine substitutes, tobacco cessation products or marijuana within the last twelve (12) months. I agree that any material misrepresentation, including smoking status, will render the insurance voidable by Manulife.

I acknowledge receipt of and agree with the Notice on Privacy and Confidentiality.

A photocopy of this signed declaration shall	be as valid as the original.				
Signed at (City/Province)	Applicant's Signature			(DD/MMM/YYYY) Dated	
	Advisor's Repo	rt • For Advisor	Use Only		
 (ou confirm that you have disclosed the follo the name of the company or companie that you receive commissions for the incentives; and any conflicts of interest you may have 	wing information to the applicant: s you represent sale of life and accident and sickne			nuses, invitations to conferences	or othe
our name (first, middle initial, last)			Advisor code		
iignature					
ist the advisors involved in this sale. N	lote: The first advisor listed wi	ll be considered the s	ervicing advisor.		
Name of servicing advisor		Advisor code		Percentage of commission _	%
Name of advisor		Advisor code		Percentage of commission _	%
Distribution channel:					
Managing General Agency (MGA)					
Name	MGA code		MGA email		
National Account					
Name	National Accounts code		National Account	s email	
Please send the completed application to:	For Regular Mail: Manulife P.O. Box 670 Stn Waterloo Waterloo, ON N2J 4B8	For Courier: Manulife 500 King Street Affinity Markets Delivery Station! Waterloo. ON N	500-GB		

Note: If you are contracted through a MGA/National Account firm, please forward the completed application to their office.

☐ Advisor, Mailing address:

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk, marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, PO Box 1602, Del. Stn. 500-4-A, Waterloo, ON N2J 4C6.

Plans underwritten by The Manufacturers Life Insurance Company.

Mail policy to: ☐ Insured

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