

Mail to: Personal Accident
 2 Queen St. E., P.O. Box 4213, Stn A
 Toronto, Ontario M5W 5M3

Agent ID

H.O. use only

Please ensure all changes/corrections are initiated by the primary insured/owner. Do not use white-out on this application.

PLEASE PRINT

Addition to Policy Number S _____

PART 1

A. Primary Insured Information

Please contact me at: Home Work Email _____

1. First Name	Middle Initial	Last Name	Maiden Name	H.O. use only
2. Number & Street		City	Province	Postal Code
3. Residence Telephone Number ()		4. Business Telephone Number ()		5. Date of Birth (dd/mm/yy)
6. Age		7. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		8. Social Insurance Number
9. Policy Language English <input type="checkbox"/> French <input type="checkbox"/>		10. Place of Birth		
11. Primary Occupation		12. Length of Time	13. Duties (detailed description)	
14. Name & Address of Company/Employer			15. Secondary Occupation	16. Hours per week
17. Are you a permanent resident of Canada? Yes <input type="checkbox"/> No <input type="checkbox"/> (Answer must be 'yes' to be eligible for insurance)		18. Will this insurance replace any existing income replacement insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> (Complete only if residing in Quebec. If "YES", complete required form)		
19. Beneficiary Note: In the Province of Quebec, unless stated to be revocable, a spousal beneficiary is irrevocable. If more than one beneficiary, benefits will be paid in equal shares, unless otherwise stated.			20. Relationship to Primary Insured	H.O. use only
21. Owner (Complete only if Primary Insured is a minor; otherwise the Owner is the Primary Insured.)		22. Owner's Date of Birth (dd/mm/yy)	23. Relationship to Primary Insured	H.O. use only

B. Accident Disability Plan

	Benefit Amount	Annual Premium
1. 24 Hour Compensation (2 Year Benefit)	<input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 120 day elimination period	\$

C. Accident & Sickness Disability Riders

Coverage Information – Please (✓)

	Coverage Information	Benefit Amount	Annual Premium
2. 24 Hour Compensation (E) (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 0 <input type="checkbox"/> 30 or <input type="checkbox"/> 120 Days	\$	\$
3. Non-Occupational Loss of Income (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 0 Days or <input type="checkbox"/> 120 Days	\$	\$
4. Sickness Disability (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 30 Days or <input type="checkbox"/> 120 Days or <input type="checkbox"/> 15 Day Retro	\$	\$
5. 24 Hour Accident Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$
6. Non-Occupational Accident Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$
7. Sickness Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$

D. Additional Riders

Coverage Information & Benefit Amount – Please (✓)

	Coverage Information & Benefit Amount	Annual Premium
1. Accidental Death & Dismemberment	Accident Death Benefit Amount: <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$300,000	\$
2. Accident Excess Medical	Accident Paramedical Services Benefit Amount: <input type="checkbox"/> Plan A – \$400 <input type="checkbox"/> Plan B – \$600 <input type="checkbox"/> Plan C – \$800	\$
3. Return of Premium	Exclude On:	\$
4. Return of Premium on Death	Exclude On:	\$
5.		\$
Total Annual Premium (Monthly Premium = Annual Premium ÷ 12)		\$

E. Eligibility – For all Plans and Riders

Answers to Questions 1, 2a), 2b) & 3 must be “No” to be eligible for any coverage.

1. Are you currently totally or partially disabled or receiving disability benefits or a disability pension?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. a) Do you have any physical impairments?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Do you have a physical impairment that limits your ability to perform your normal occupation(s) and/or engage in all of the functions of your normal daily routine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Are you currently receiving social assistance (welfare) benefits?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>

F. Employment Eligibility

Complete for Accident and Sickness disability benefit amounts exceeding \$1,000 per month AND for ANY amount of 24 Hour Accident Disability Extension, Non-Occupational Accident Disability Extension and Sickness Disability Extension.

1. Do you currently work 30 or more hours per week? (Answer must be “Yes” to be eligible).....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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G. Financial Information and Existing Insurance

Complete for Accident and Sickness disability benefit amounts exceeding \$2,000 per month for ANY coverage under Part 1, Sections B. & C.

1. Gross Annual **Personal** Earned Income (subtract E.I./U.I.) _____ x 75% = _____ ÷ 12 = _____ /Eligible Monthly Income.
(Employees: T1, lines 101 + 104. Self-Employed: T1, lines 135 to 143)

2. If self-employedGross Annual **Business** Income _____
 – Purchases; sub-contracts; wages & salaries; investment; interest; rental & government plan incomes _____
 (Business Income: T2124, lines 8299 less lines 8300 to 8515 and 9060) = Eligible Business Income _____

a) No full-time employees:
 Eligible Business Income _____ x % of ownership _____
 = _____ x 75% = _____ ÷ 12 = _____ / Eligible Monthly Income.

b) With full-time employees:
 Eligible Business Income _____ x % of ownership _____
 = _____ x 1% = _____ / Eligible Monthly Income.

3. Are you covered by the Worker’s Compensation Board in your province of residence? Yes No
 If “Yes”, provide coverage amount below. This amount will be considered when calculating the monthly benefit you qualify for.

4. Do you currently have Disability Insurance? Yes No
 If “Yes”, provide details below. This amount will be considered when calculating the monthly benefit you qualify for.

Question No.	Details

PART 2

Primary Insured _____

H. Medical Questionnaire for Sickness Disability and Sickness Disability Extension.

Date of Birth _____

Before applying, it is important to understand that this coverage is not available to you if you have any of the following conditions:

Active hepatitis	AIDS or AIDS-related disease	Alcohol abuse in the past 5 years
Alzheimer's disease	Any heart condition or heart trouble (excluding controlled hypertension)	Cancer – except basal cell skin cancer
Coronary bypass surgery	Diabetes	Heart attack
Huntington's Chorea	Lou Gehrig's disease – amyotrophic lateral sclerosis (ALS)	Lupus
Multiple Sclerosis	Stroke – cerebrovascular accident	Transient Ischemic Attack

Your Physician's Name: _____ Physician's Address: _____

Date last seen: _____ Reason last seen: _____

Tests, treatment, medication prescribed (if none, state "None"): _____

Results and current status: _____

Your height: _____ ft & in/cm Your current weight: _____ lb/kg Has your weight changed in the past year? Yes No

If yes: Gained _____ lb/kg Lost _____ lb/kg Reason for change: _____

PLEASE ANSWER ALL QUESTIONS AND PROVIDE FULL DETAILS BELOW OR ATTACH A SEPARATE SHEET, SIGNED AND DATED. HAVE YOU:

- Ever applied for any insurance that was declined, modified or rated? Yes No
If yes, give date, name of company and reason: _____
 - Within the past 7 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? Yes No
If yes, give details including drug or alcohol type(s) and date(s) last used: _____
 - Female applicants only: Are you currently pregnant? Yes No
If yes, give due date: _____
Have you ever had a miscarriage, preeclampsia, caesarean section or other complication of pregnancy? Yes No
If yes, give date and details: _____
 - Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), positive test, treatment for or exposure to HIV virus, kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned? Yes No
 - Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc), arthritis, paralysis or weakness, fibromyalgia or chronic pain, had x-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks? Yes No
 - Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu etc), been advised to undergo further investigation, see another doctor or have surgery? Yes No
- If you answered "yes" to Questions 4 through 6 above, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question #	Nature of Disorder	Date and Duration	Treatment and Current Status	Attending Physician or Hospital

- Have any of your parents, brothers or sisters had heart disease, diabetes, cancer, stroke, high blood pressure, kidney disease, hepatitis, Huntington's Chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease or genetic disorder? Yes No
If yes complete the following:

Family Member	Condition (if cancer, specify type)	Age of Onset	Age at Death and Cause

The insurer may request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV) which will be made at no expense to the applicant. Results of any positive infectious disease test will be reported to the appropriate health department if required by law.

I understand that the coverage I am applying for may be rescinded due to non-disclosure of medical history. _____ (client initials)

Important Notice on Exchange of Information

All information requested will be for insurance purposes only and will be treated as confidential. The Insurer or its reinsurers may, however make a brief report on it to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, the bureau will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, the bureau will arrange for disclosure to you of any information it may have in your file on you. If you question the accuracy of the bureau's file, you may contact the bureau and seek a correction. The address of the bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

Important 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 Financial 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 Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), 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 Financial at the address shown below. Your file is secured in our offices or the office of the administrator. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 2 Queen St. E., P.O. Box 4213 Stn A, Toronto, Ontario M5W 5M3.

Temporary Insurance Agreement

Manulife Financial, (the Company) agrees to provide Temporary Insurance coverage as applied for, provided the initial premium or credit card billing has been honoured by the financial institution and the questions in Section (E) are answered "NO", (reference # 1, 2a), 2b), or 3), subject to the following:

1. The terms, conditions, limitations, and exclusions, and other provisions of the policy applied for, will govern.
2. This agreement **DOES NOT** cover Sickness Disability or Sickness Disability Extension.
3. Temporary Insurance coverage ceases on the earliest of:
 - a) the date the policy applied for becomes effective; or
 - b) sixty (60) days from the date of the Payment Acknowledgement noted below; or
 - c) the date the Company sends notice to the proposed Primary Insured declining the application.

No representative of Manulife Financial is authorized to modify this agreement.

Payment Acknowledgement

The Company acknowledges payment of or authorization to bill the initial premium of \$ _____

Signature of Agent _____ Date _____