The Manufacturers Life Insurance Company
CPA Select* Insurance Plans

APPLICATION FOR CRITICAL ILLNESS INSURANCE

Pre-Screen Checklist

Before applying for Critical Illness Insurance, it is important to understand that this plan is not available to you if you or your Spouse (if applying) have or have ever had any of the following conditions or procedures:

- Active hepatitis
- AIDS or AIDS-related disease
- Alcohol abuse in the past five years
- Alzheimer's disease
- Any heart condition or heart trouble (excluding controlled hypertension)
- Cancer – all cancer except basal cell skin cancer
- Coronary bypass surgery
- Diabetes
- Heart attack
- Huntington's chorea
- Kidney disease – other than kidney stones or a history of kidney infection
- Lou Gehrig's disease – amyotrophic lateral sclerosis (ALS)
- Major organ transplant recipient
- Multiple sclerosis
- Permanent paralysis (paraplegia, quadriplegia) – other than Bell's palsy
- Pulmonary fibrosis
- Stroke – cerebrovascular accident
- Transient ischemic attack

Section 1: Applicant Information

Last Name First Name ☐ Male ☐ Female

Home Address Unit/Apt. City Province Postal Code

Preferred Contact Number Email

Date of Birth DD/MM/YYYY Place of Birth (province, country) ☐ Smoker ☐ Non-Smoker*

Occupation

If self-employed, please describe the nature of your business/duties:

Applicant is a member of the Chartered Professional Accountants of:

☐ Ontario ☐ Bermuda ☐ New Brunswick
☐ Nova Scotia ☐ Prince Edward Island ☐ Newfoundland/Labrador Membership No.:

Spouse Information (if applying for Spouse coverage)

Spouse Last Name First Name ☐ Male ☐ Female

Spouse's Date of Birth DD/MM/YYYY Place of Birth (province, country) ☐ Smoker ☐ Non-Smoker*

Spouse's Occupation (If self-employed, please describe nature of business/duties):

Preferred Contact Number:

*Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products, including e-cigarettes, in the past 12 months.

Section 2: How much insurance are you applying for?

Do not include any existing coverage.
(Minimum amount of critical illness coverage available is $50,000. Maximum amount of critical insurance coverage available is $250,000.)

Applicant

Indicate the amount you require in $25,000 increments.
(10% discount applies to amounts of $125,000 or more!)

$,000
Coverage amount

Spouse

Indicate the amount you require in $25,000 increments.
(10% discount applies to amounts of $125,000 or more!)

$,000
Coverage amount

Existing Coverage

Does any applicant have any pending or existing critical illness insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Name of Applicant	Insurance Company Name	Personal or Business	Do you intend to replace this coverage?
		☐ Personal ☐ Business	☐ Yes ☐ No
		☐ Personal ☐ Business	☐ Yes ☐ No
		☐ Personal ☐ Business	☐ Yes ☐ No

Note: If you intend to replace coverage (other than coverage you may have through an employer group benefits plan), do not cancel your existing coverage.
A replacement form or declaration may be required. We may not be able to issue an insurance policy if replacement is indicated.

Section 3: Beneficiary Information

Beneficiary(ies) on applicant's coverage:

I (the applicant) hereby designate the individual(s) named below to receive any death benefit payable with respect to the coverage applied for.
If no beneficiary is designated, benefits will be payable to the Estate.

1. Last Name First Name

   Relationship to you, the applicant % of Benefit

2. Last Name First Name

   Relationship to you, the applicant % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

1. Last Name First Name

   Relationship to beneficiary % of Benefit

For Quebec residents only: In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. **(Check box below if designation is to be revocable.)**

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Beneficiary(ies) on Spouse's coverage:

I (the applicant) hereby designate the individual(s) named below to receive any death benefit payable with respect to the coverage applied for.
If no beneficiary is designated, benefits will be payable to the Estate.

1. Last Name First Name

   Relationship to Spouse % of Benefit

2. Last Name First Name

   Relationship to Spouse % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

1. Last Name First Name

   Relationship to beneficiary % of Benefit

For Quebec residents only: In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. **(Check box below if designation is to be revocable.)**

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Section 4: Financial Information

1. **Applicant:** What is your occupation?
2. **Applicant:** What is your annual earned income (income after expenses and before taxes)? $
3. **Spouse:** What is your annual earned income (income after expenses and before taxes)? $
4. **Applicant and Spouse:** What is your combined personal net worth (assets minus liabilities)? $

Section 5: Payment Information

Method of Payment

To apply securely using your credit card call **1 866 219-4245** or visit the website.

☐ Annual

My cheque is enclosed, made payable to "Manulife" **(ANNUAL only)**

$		X		+		= $	
	Total monthly premium		No. of months to June 1 (excluding present month)		Provincial sales tax if applicable		**AMOUNT PAYABLE TO NEXT JUNE 1**
					0.00%		0.00

☐ Monthly

By pre-authorized debit – PAD (please enclose a sample cheque marked "VOID")

We'll calculate the provincial sales tax (if applicable), as well as any volume discounts you may be eligible for.

For your convenience, if you choose payment by pre-authorized debit or credit card, your future premium billings will automatically reflect the same payment method.

Payment Information

For pre-authorized debit (PAD) payment option

Name of Account Holder Financial Institution

Address of Financial Institution City/Town

Bank Account Number Transit Number

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ Current ☐ Direct Deposit Account ☐ Other

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 this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

Payment authorization for pre-authorized debit (PAD) payment options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account on the day on which insurance premiums are due or after I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive 10 days notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by Payments Canada in Rule H-1. I/We or Manulife may end this agreement at any time by giving 10 days written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1 866 219-4245 or am_service@manulife.com, or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a reimbursement claim, or for more information on your recourse rights, contact your financial institution or visit www.payments.ca.

Name of Account Holder Signature of Account Holder _____

Second signature if joint account_____ Dated DD/MM/YYYY

Account holder address (if different from applicant)

Quebec residents may detach and mail the following three pages separately to the insurer. This application is not valid unless a properly completed Health Declaration is received by Manulife.

Section 6: Health Declaration

Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.

Applicant's Name | Applicant's Phone Number

Physician's Name | Physician's Phone Number

Physician's Address

Date and reason of last consultation:

Result of last consultation, and any treatment or medication prescribed:

Height (include ft & in or cm): | Weight (include lb or kg):

Has your weight changed by more than 10 lbs (4.5 kg) in the past 12 months? ☐ Yes ☐ No

If yes: ☐ Gained (include lb or kg): | ☐ Lost (include lb or kg):

Reason for change:

If applying for Spouse

Physician's Name | Physician's Phone Number

Date and reason of last consultation:

Result of last consultation, and any treatment or medication prescribed:

Height (include ft & in or cm): | Weight (include lb or kg):

Has your weight changed by more than 10 lbs (4.5 kg) in the past 12 months? ☐ Yes ☐ No

If yes: ☐ Gained (include lb or kg): | ☐ Lost (include lb or kg):

Reason for change:

Section 7: Your Personal Information

Please ensure all questions are answered and details provided for all individuals applying for coverage. If you require additional space, please use a separate page, signed and dated.

	Applicant YES	Applicant NO	Spouse YES	Spouse NO
Have you:				
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:	☐	☐	☐	☐
2. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked:	☐	☐	☐	☐
2. b) Within the past 2 years, been charged with or convicted of 2 or more moving or traffic violations (for example, speeding, failure to stop, seat belt violations, distracted driving or failure to provide a breathalyzer sample)? If yes, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province/territory:	☐	☐	☐	☐

Section 7: Your Personal Information (continued)

	Applicant YES	Applicant NO	Spouse YES	Spouse NO
3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s):	☐	☐	☐	☐
4. Within the next 12 months: a) Any expectation to travel outside Canada and the United States of America? If yes, give details including where, when, why and for how long:	☐	☐	☐	☐
b) Any expectation to change your country of residence? If yes, provide details, including where you intend to move, when you are moving, why you are moving and if your occupation is changing:	☐	☐	☐	☐
5. Within the past 5 years: a) Used any drugs other than for medical purposes; used marijuana; or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug(s) used, alcohol type(s), daily consumption and date(s) last used:	☐	☐	☐	☐
b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details:	☐	☐	☐	☐
c) Declared, or are you currently contemplating personal or business bankruptcy? If yes, provide details including date of discharge:	☐	☐	☐	☐

Section 8: Your Medical Information

IMPORTANT: Any reference to testing, tests, test results or investigations in this section 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.

1. Has any individual proposed for coverage (applicant, spouse) ever had any indication of or been treated for conditions involving any of the following:	Applicant YES	Applicant NO	Spouse YES	Spouse NO
a) **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐	☐	☐	☐
b) **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐	☐	☐	☐
c) **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐	☐	☐	☐
d) **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐	☐	☐	☐
e) **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐	☐	☐	☐
f) **Your brain or nervous system** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐	☐	☐	☐
g) **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐	☐	☐	☐
h) **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐	☐	☐	☐
i) **Your blood or glands**, such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐	☐	☐	☐

Section 8: Your Medical Information (continued)

	Applicant YES	Applicant NO	Spouse YES	Spouse NO
j) **Your muscles, bones or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints or spine causing any physical limitations or restrictions, or other?	☐	☐	☐	☐
k) **Your skin,** such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size or colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐	☐	☐	☐
l) **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐	☐	☐	☐
m) **Cancer**, cysts, lumps, polyps, or tumour?	☐	☐	☐	☐
n) **Other illness or disorder** not mentioned above, or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐	☐	☐	☐
2. If female, a) are you currently pregnant?	☐	☐	☐	☐

If yes, give your due date and the name and address of your obstetrician/gynecologist:

b) What was your pre-pregnancy weight? lb/kg

c) Have there been any complications with your pregnancy? If yes, provide details:	☐	☐	☐	☐
3. Within the past 2 years, have you:				
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐	☐	☐
b) Consulted a specialist or been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	☐	☐	☐	☐
c) Been advised to undergo further investigation, see another doctor or have surgery?	☐	☐	☐	☐
d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐	☐	☐

If you answered yes to any part of questions 1, 2 and 3 above, please give details below:

Question No.	Name of Applicant	Nature of Disorder	Date & Duration	Treatment & Current Status (If none, state "None")	Attending Physician or Hospital

Family Medical History

	Applicant YES	Applicant NO	Spouse YES	Spouse NO
4. Have any of your parents or siblings (brothers or sisters): a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐	☐	☐
b) Ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis or retinitis pigmentosa?	☐	☐	☐	☐

If you answered yes to a) or b) above, please complete the following:

Name of Applicant	Family Member	Condition (If cancer, specify type)	Age at Onset	Age at Death & Cause, if applicable

Information about MIB, LLC

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, LLC based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, LLC is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, LLC will share any information it has on file. You may review the information in your file, and request a correction if necessary, by contacting MIB, LLC at:

MIB, LLC
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

Personal Information Statement

At Manulife protecting your personal information and respecting your privacy is important to us.

"We", "us" and "our" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Why do we collect, use, and disclose your personal information?

For the purposes of establishing and managing our relationship with you, providing you with products and services, administering our business, and complying with legal and regulatory requirements.

What personal information do we collect?

Depending on the product or service, we collect specific personal information about you such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, driver's license, passport number or your Social Insurance Number (SIN)
- Financial information, investigative reports, credit bureau report, and/or a consumer report
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking and employment information
- Medical information that any organization or person has about you
- Any test that may be necessary for underwriting purposes
- Other personal information that we may require to administer your products or services and manage our relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

Depending on the product or service, we collect personal information from:

- Your completed applications and forms
- Other interactions between you and us
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal with in issuing and administering your products or services now, and in the future
  - Public sources, such as government agencies, credit bureaus and internet sites
  - Financial institutions
  - Your employer or Plan Sponsor and their authorized agents, consultants and plan service providers
  - The MIB, LLC (formerly known as the Medical Information Bureau)
  - Health Care Professionals, including Medical Practitioners, health care institutions, pharmacy and any other medically-related facility

What do we use your personal information for?

Depending on the product or service, we will use your personal information to:

- Administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us make decisions and understand our customers better so we can improve the products and services we provide
- Perform audits, and investigations and protect you from fraud
- Determine your eligibility for, and provide you with details of, other products and services that may be of interest to you
- Automate processing to help us make decisions about your interactions with us, such as, applications, approvals or declines

Who do we disclose your information to?

Depending on the product or service, we disclose your personal information to:

- Persons, financial institutions, reinsurers, and other parties with whom we deal with in issuing and administering your product or service now, and in the future
- Authorized employees, agents and representatives
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- Your employer or Plan Sponsor and their authorized agents, consultants and plan service providers
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your doctor
- Public health authorities as required

Except where there are contractual restrictions, these people, organizations and service providers are both within Canada and outside of Canada. Therefore, your personal information may be subject to interprovincial or cross-border transfers in order to provide services to you and subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

Withdrawing your consent

You may withdraw your consent for us to use your personal information for certain uses, subject to legal and contractual restrictions.

You may not withdraw your consent for us to collect, use, or disclose personal information we need to issue or administer your products and services. If you do so, we may not be able to provide you with the products or services requested or we may treat your withdrawal of consent as a request to terminate or refusal of the product or service.

If you wish to withdraw your consent, phone our customer care centre at **1-877-268-3763**, or write to the Privacy Officer at the address below.

Accuracy

You will notify us of any change to your contact information. If your information has changed, or if you need to make a correction of any inaccuracies to your personal information in our files, you may contact us at **1-877-268-3763**.

Access

You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. Requests can be sent to: **Privacy Officer, Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**.

For more information you can review our **Canadian Privacy Policy**. Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email.

Declaration and Authorization – Please read carefully before signing.

I (the Applicant) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

I (the Applicant) understand and agree that if I am no longer a member of at least one of the participating bodies from New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island or Bermuda, for any reason whatsoever, any new or additional coverage issued pursuant to this application, together with any previously issued coverage under the Plans will be terminated. I (the Applicant) understand that it is my responsibility to inform Manulife if my membership terminates.

I/We declare that the statements contained in this application, including the health declaration originally attached hereto, are true and complete. I/We understand that this application, together with any other forms signed by me/us in connection with this application, forms the basis for any certificate issued hereunder. The person(s) to be insured understand(s) that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I/We understand that exclusions and limitations apply to the coverage applied for. Suicide within the first two years is a risk not covered. Relative to the insurance applied for, I/we, the person(s) to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB, LLC, the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me/us or my/our health or the health of any member of my/our family to be insured pursuant to this application to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I/We authorize Manulife to consult its existing files for this purpose.

I/We authorize Manulife, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me/us their products or services. I/We understand that my/our consent to the use of such information to offer me/us products or services is optional, and that if I/we wish to discontinue such use, I/we may write to Manulife at the address shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/We acknowledge receipt of and confirm my/our agreement with the Information about MIB, LLC and Personal Information Statement.

I (the Applicant) hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my or, if applicable, my Spouse's death.

I/We declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. I/We understand that this consent may be revoked at any time and that, if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

I acknowledge that the insurer may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be made at no expense to me/us. I/We further acknowledge that results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law, and that, based on my/our health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

I/We acknowledge that coverage will take effect on the date the properly completed application (including my/our properly completed health declaration) and the first premium are received by Manulife, subject to of the Company's underwriters. If I am/we are applying for new coverage and am/are approved, I/we will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am/we are not insurable, a full refund of the premiums will be made.

By providing your email address herein, you consent to us providing information or documents to you in respect of this application or policy, as applicable, in electronic form.

Quebec residents only:

The French version of the application was provided, I wish to complete the English version. As per Quebec law, I will receive the Certificate of Insurance in both English and French and all further related documentation will be sent exclusively in English.

Signature of Applicant _____ Signed at City, Province/Territory Date DD/MM/YYYY

Signature of Spouse _____ Signed at City, Province/Territory Date DD/MM/YYYY

Questions?

Contact Manulife toll-free at **1 866 219-4245**
Monday to Friday, 8 a.m. to 8 p.m. ET

By email anytime at **am_service@manulife.com**
Or online at **CPAselectplans.ca**

Please send your completed application, along with payment, to:
Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8

Accessible formats and communication supports are available upon request. Visit **manulife.ca/accessibility** for more information.

Manulife

CPA ONTARIO

This coverage is underwritten by **The Manufacturers Life Insurance Company (Manulife).**

*CPA Select and CPA Select Plans are official marks of the Chartered Professional Accountants of Canada.
CPA Select Insurance Plans are sponsored by the Chartered Professional Accountants of Ontario and underwritten by The Manufacturers Life Insurance Company.Manulife, Stylized M Design, and Manulife & Stylized M Design are trademarks of The Manufacturers Life Insurance Company and are used by it, and by its affiliates under license.