The Manufacturers Life Insurance Company (Manulife)

CPA Select* Health & Dental Plan Application

H41

All applicants must complete Parts A, B, C, D and E. All applicants must complete and sign Applicant's Authorization and Declaration.

All applicants must have coverage under a Canadian provincial/territorial health care insurance plan in order to be eligible for this insurance product. If anyone on the application does not meet this requirement, please contact our Customer Service for more information.

When you apply for insurance, your beneficiary is set as your estate. To change this, please log into SecureServe at manulife.ca/secureserve.

Part A – General Information

Primary Applicant

Last Name First Name Initial

Does each applicant have provincial/territorial health care coverage? ☐ Yes ☐ No

Home Address Unit/Apt. City Province Postal Code

Home Telephone Office Telephone

Email (optional)

If additional information is required, how may we contact you? ☐ Home ☐ Office ☐ Email

Applicant is a member of the Chartered Professional Accountants of:

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

Co-Applicant

Last Name First Name

Telephone Email (optional)

If additional information is required, how may we contact you? ☐ Telephone ☐ Email

Are you now covered by or did you recently have employer group health insurance coverage? ☐ Yes ☐ No
If yes, please indicate:

Primary Applicant

Group Plan Number ID Number

Insurance Company Date Benefits Ended DD/MM/YYYY

Co-Applicant

Group Plan Number ID Number

Insurance Company Date Benefits Ended DD/MM/YYYY

Part B – Plan Choice

Remember: Your plan choice applies to all family members.

I/We apply for the following plan:

☐ CPA Select Starter Health & Dental**

☐ CPA Select Essential Health or ☐ CPA Select Essential Health & Dental

☐ CPA Select Enhanced Health or ☐ CPA Select Enhanced Health & Dental

Add-Ons

☐ CPA Select Essential Catastrophic Rider

☐ CPA Select Enhanced Catastrophic Rider

** This plan does not require completion of the Medical Questionnaire in this application.

Part C – Individuals to be Covered

Last Name	First Name	Code	Sex	Birth date DD/MM/YYYY	Age	Smoker? No. of Cigarettes Daily	Height inch/cm ☐ ☐	Weight lbs/kg ☐ ☐	Weight change in last year gain	loss	Reason for weight change
Applicant		00									
Co-applicant		01									
Dependant		02									
Dependant		02									
Dependant		02									
Dependant		02									

If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

Part D – Medical Questionnaire

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence no earlier than the first of the month following final approval of this application and receipt of first premium payment.

All applicants must complete and sign the Applicant's Authorization and Declaration.

Additional medical information may be required to underwrite your application. If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

Pre-existing Illness Or Conditions Ineligible for Coverage

Please note this is a partial list of the most common ineligible conditions and there may be other conditions ineligible for coverage.

- pending investigations, tests or surgery
- heart attack, angina, stroke, atrial fibrillation
- coronary artery disease, peripheral vascular disease, aneurysm
- angioplasty or coronary artery bypass grafting
- diabetes diagnosed prior to age 50 (excluding gestational diabetes fully resolved)
- cancer diagnosed and/or treated within the last ten years
- anxiety, depression or mood disorder with recent treatment initiated or dosage change; recent hospitalization or time off work
- Alzheimer's disease, dementia, Parkinson's, multiple sclerosis
- Huntington's disease, muscular dystrophy
- AIDs or HIV positive
- Down's syndrome, cerebral palsy, cystic fibrosis, spina bifida
- Drug/alcohol abuse within last five years

Medical Declaration

1. Name of physician or health care worker who holds the majority of your medical records:

   Applicant:

   Co-Applicant:

   Children:

   Provide the date and reason you, your co-applicant and your children last consulted with a physician or health care worker, including walk-in clinic or tele-health consultations:

   Applicant:

   Co-Applicant:

   Children:

Medical Declaration

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.

	Applicant YES	Applicant NO	Co-Applicant YES	Co-Applicant NO	Child(ren) YES	Child(ren) NO
2. Do you have any symptoms or concerns for which you have not yet consulted a doctor or health care worker?	☐	☐	☐	☐	☐	☐
3. In the **last 5 years**, have you, your co-applicant or children:						
a) had any doctor or health care worker recommend any tests, treatment, examination, surgery (including day surgery), hospitalization, or referrals that have not been completed or are you, your co-applicant or children currently awaiting test results?	☐	☐	☐	☐	☐	☐
b) been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks?	☐	☐	☐	☐	☐	☐
4. Are you currently using any prescribed medication, medical equipment or testing device or do you expect to do so in the **next 3 months** (exclude birth control, medication for cold or flu)?	☐	☐	☐	☐	☐	☐
5. For the following questions have you, your co-applicant or children ever had any consultation with any doctor or health care worker about:						
a) High blood pressure or high cholesterol?	☐	☐	☐	☐	☐	☐
b) Heart attack, stroke, transient ischemic attack (TIA), chest pain, or other heart or circulatory disease or disorder?	☐	☐	☐	☐	☐	☐
c) Chronic pain, any back, joint or musculoskeletal pain or disorder, fibromyalgia, gout, arthritis, rheumatoid arthritis, lupus, scleroderma, osteopenia/osteoporosis, or paralysis, weakness or numbness?	☐	☐	☐	☐	☐	☐
d) Crohn's disease, colitis, ulcerative colitis, irritable bowel disorder, acid reflux, cirrhosis, hepatitis including carrier state, or other stomach, bowel, pancreas or liver disorder?	☐	☐	☐	☐	☐	☐
e) Depression, anxiety, stress, sleep disorder, attention deficit disorder (ADD), eating disorder, autism or any other psychological or emotional disorder?	☐	☐	☐	☐	☐	☐
f) Epilepsy, multiple sclerosis, Alzheimer's disease, dementia, Parkinson's disease, or any other nervous system disease or disorder?	☐	☐	☐	☐	☐	☐
g) Headaches or migraines?	☐	☐	☐	☐	☐	☐
h) Alcohol or drug abuse, or any addiction?	☐	☐	☐	☐	☐	☐
i) Allergies, asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or other respiratory disease or disorder?	☐	☐	☐	☐	☐	☐
j) Testing or treatment (including prophylactic treatment), for AIDS or HIV (exclude routine negative testing for pregnancy, blood donation, immigration or insurance)?	☐	☐	☐	☐	☐	☐
k) Cancer, tumor, leukemia or lymphoma, or any cyst(s) or growth(s)?	☐	☐	☐	☐	☐	☐
l) Acne, rosacea, eczema, psoriasis, or other skin disease or disorder?	☐	☐	☐	☐	☐	☐
m) Infertility or assisted conception, polycystic ovary syndrome (PCOS), or other breast or reproductive disorder?	☐	☐	☐	☐	☐	☐
n) Kidney disease or disorder, interstitial cystitis or other bladder disorder, benign prostatic hyperplasia or other prostate disorder, genital herpes or any other sexually transmitted diseases or infections (STDs or STIs)?	☐	☐	☐	☐	☐	☐
o) Diabetes or elevated blood sugar, hyperthyroid, hypothyroid, pituitary disorder, or other endocrine disease or disorder?	☐	☐	☐	☐	☐	☐
p) Cataract(s), glaucoma, loss of vision, impaired hearing, tinnitus, any balance disorder, or other eye or ear disease or disorder?	☐	☐	☐	☐	☐	☐
6. Are you or your co-applicant currently pregnant?	☐	☐	☐	☐		
If yes, have you or your co-applicant ever experienced complications with current or any prior pregnancy?	☐	☐	☐	☐		

Please provide the expected delivery date: DD/MM/YYYY and pre-pregnancy weight (include lb. or kg.):

If you have answered yes to any of these questions, please provide full details below:

Person to be insured	Question	Details, diagnosis if known, treatment history, testing dates, reason for tests, results of tests, recurrence and names of all attending doctors.

Catastrophic Coverage Medical Questionnaire

Must also complete Sections A and C when applying for the Catastrophic Coverage Rider (available as an add-on).

1. Have you, your co-applicant or any listed dependant(s), natural parents, brother(s), sister(s), either living or dead, ever suffered from any of the following conditions: heart disease, stroke, cancer (specific type), 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? ☐ Yes ☐ No

   If yes, please complete the section below.

Name of Individual	Relationship to Proposed Insured	Condition	Age at Onset	Age at Death	Cause of Death

2. Have you, your co-applicant or any children in the last 2 years flown as a private pilot, or participated in any activities of a hazardous nature, such as motor vehicle racing, skin or scuba diving, sky diving, mountain climbing, hang-gliding, or do you expect to participate in the next 12 months? ☐ Yes ☐ No

   If yes, please indicate the name of the activity and person participating.

   A supplemental questionnaire may be sent to you for completion.

3. Have you, your co-applicant or any children in the last 2 years had your driver's licence suspended, revoked or been convicted of 3 or more moving violations? ☐ Yes ☐ No

   If yes, please provide full details including the date and reason licence was suspended or revoked and date reinstated.
   Also include the kilometres over for each moving violation and the date of each violation.

   A supplemental questionnaire may be sent to you for completion.

Part E – Payment Options

Initial Payment: I/We hereby authorize Manulife to debit the initial two (2) months' premium, $, using my/our:

☐ Pre-Authorized Debit (PAD)

Important: Initial payment will be taken on the **day approved** (not the effective date). Future payments will be taken on the first of each month. To apply securely using your credit card, contact our licensed insurance advisors at **1 866 219-4245** or **more_info@manulife.com**.

Subsequent payments will be made by:

Option #1 ☐ Pre-Authorized Debit (PAD)

PAD Billing Frequency: ☐ Monthly ☐ Semi-Annual (2% savings) ☐ Annual (4% savings)

Important: For verification purposes, we require a sample cheque marked 'VOID'.

Option #2 ☐ Direct Billing

Direct Billing Frequency: ☐ Semi-Annual (2% savings) ☐ Annual (4% savings)

Pre-Authorized Debit (PAD) Payment Information & Payment Authorization

Please use the following banking information:

☐ From the cheque used to make the first payment **or**

☐ As follows (only complete the information below if you do not have a void cheque):

Name of Account Holder

Transit Number Institution Number Bank Account Number

Financial Institution Address of Account Holder

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.

For Pre-Authorized Debit (PAD) Payment Options

I/We hereby authorize Manulife to make a withdrawal from my/our bank account on a monthly, Semi-Annually or Annual frequency on the day on which insurance premiums are due for insurance premiums due on 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 further 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 more_info@manulife.ca, 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.

Signature of Account Holder _____ Dated DD/MM/YYYY

Second Signature if Joint Account _____ Dated DD/MM/YYYY

Account Holder Address (if different from Applicant)

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.

Applicant's Authorization and Declaration

All applicants must complete this section.

I/We hereby acknowledge that the statements contained herein are true and complete and, together with any other forms signed by me/us in connection with this application, form the basis for any policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any 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 under this plan, to provide any such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with Manulife's Personal Information Statement. I/We understand and agree that coverage shall not become effective until the first of the month following final approval and receipt of the first premium payment.

A photocopy of this signed authorization shall be as valid as the original.

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 Date DD/MM/YYYY

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

For more information about these and other CPA Select-sponsored plans or to apply, visit the website at **CPAselectplans.ca** today.

If you need assistance or to speak to a licensed insurance advisor, call us toll-free at **1 866 219-4245**
Monday to Friday, 8 a.m. to 8 p.m. ET

or email **am_info@manulife.com**.

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

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

CPA ONTARIO Manulife

*CPA Select and CPA Select Plans are official marks of the Chartered Professional Accountants of Ontario.