engineerscanada

Engineers Canada-sponsored Plan:

APPLICATION FOR DISABILITY INSURANCE

The Manufacturers Life Insurance Company

1. MEMBER INFORMATION

Name of Member (PLEASE PRINT) Last: _____ First: _____ Male ☐ Female ☐

Unit/Apt. No.: _____ No./Street: _____ City: _____ Province: _____ Postal Code: _____

Email: _____ Tel. Res.: ( ) _____ Bus.: ( ) _____

Member's Date of Birth (DD/MM/YYYY): _____ Country of Birth: _____ Non-smoker* ☐ Smoker ☐

Applicant is a/an: ☐ Engineer ☐ Engineering Student ☐ Technician/Technologist ☐ Limited Licencee
☐ Geologist/Geoscientist ☐ Architect ☐ Permanent Full-Time Employee of Association ☐ Member-in-Training

Name of Prov./Terr. Assoc. _____ Membership No. _____

* Non-Smoker applies to people who have not used any form of tobacco or tobacco cessation products in the last 12 months.

2. I AM APPLYING FOR ☐ New coverage ☐ Additional coverage

Disability Income Replacement (Do not include any coverage currently in force.)

A. Please indicate the monthly benefit amount you are applying for in $100 increments (maximum $15,000): $ _____

B. Choose a Waiting Period before benefits begin: ☐ 0–7 days ☐ 14 days ☐ 30 days ☐ 90 days ☐ 119 days ☐ 180 days ☐ 365 days

Business Overhead Expense

A. Please indicate the monthly total reimbursement benefit amount you are applying for in $100 increments (maximum $8,000): $ _____

B. Choose a Waiting Period before benefits begin: ☐ 14 days ☐ 30 days

3. OTHER INSURANCE

Do you have any pending or existing disability or overhead expense insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Company Name	Coverage Amount	Type of Insurance	Waiting Period	Benefit Period	Taxable?	Will this coverage be replaced?
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ 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. In Quebec, a replacement form or declaration may be required. We may not be able to issue an insurance policy if replacement is indicated.

4. YOUR FINANCIAL INFORMATION

A. Your employment status: Employee (no ownership) ___ Self-employed ___

B. Occupational duties (give description of duties and percentage of time performing each): _____

C. If self-employed, what is the organizational structure of your business?

Sole proprietor ___ Partnership ___ Corporation ___ If incorporated, give percentage of ownership: ___%

D. How long have you been self-employed? Since _____ (MM/YYYY)

E. If self-employed less than two years, give details of previous employment history, if any:

_____

F. How many hours do you work per week? _____

G. Do you have any part-time or other full-time jobs? ☐ Yes ☐ No

If yes, provide details: _____

H. Do you expect your income or employment situation to change within the next 12 months? ☐ Yes ☐ No

If yes, provide details _____

I. What is your share of Average Monthly Overhead Expenses, not including salary paid to yourself (complete only if self-employed and applying for Office Overhead Expense) : $_____

Proof of Income:

If applying for more than $3,500/month total Disability Income Replacement coverage (applied for and existing), please submit pages 1, 2 and 3 of your last two years' tax returns. If incorporated, please also submit your last corporate financial statement.

This coverage is underwritten by The Manufacturers Life Insurance Company.

Complete the following only if applying for Disability Income Insurance Plan

A. What was your Net Annual Earned Income (after regular business expenses but before taxes)? Last year: $_____

Two years ago: $_____

B. Is your net worth (assets minus liabilities other than personal use assets such as residence, automobile, jewelry) greater than $4,000,000? ☐ Yes ☐ No

C. Do you have any income which will become payable or continue should you become disabled? ☐ Yes ☐ No

D. If yes, indicate annual amount and source: _____

E. Is your unearned or investment income for last year greater than $30,000 or 15% of your insurable Net Annual Earned Income?

_____

F. Are you eligible for employment insurance? _____

Complete the following only if applying for Business Overhead Expense Insurance Plan

A. Please indicate the monthly total reimbursement benefit amount you are applying for in $100 increments: _____

B. What are your total monthly business expenses? _____

C. Do you share office expenses? ☐ Yes ☐ No

If yes, what is your percentage share? _____

5. BENEFICIARY INFORMATION

Beneficiary on Member Death Benefit

I (the Member) 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.

Beneficiary(ies):

1. Last Name: _____

   First Name: _____

   Relationship to Member: _____

   % of Benefit: _____

2. Last Name: _____

   First Name: _____

   Relationship to Member: _____

   % of Benefit: 100

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:

Last Name: _____

First Name: _____

Relationship to Beneficiary: _____

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.

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

6. YOUR PERSONAL INFORMATION

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

Have you:	**Member** Yes	No
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 five 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:		
b) Within the past two 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 no. and licensing province:		
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 five years:		
a) Used any drugs for other than 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 offense or are you currently charged with one?	☐	☐
If yes, please provide details:		
c) Declared, or are you contemplating personal or business bankruptcy?	☐	☐

7. HEALTH 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.

Member's Name_____ Member's Tel. ( )_____

Member's Physician – Name_____Tel. ( )_____Date Last Seen (DD/MM/YYYY)_____

Reason and result of the last consultation_____

Tests, Treatment, Medication Prescribed (If none, state "None")_____

Member's Height: _____ ☐ ft/in ☐ cm Weight: _____ ☐ lbs ☐ kg

Has your weight changed in the past year? ☐ Yes ☐ No

If yes: Gained _____ lbs/kg Loss _____ lbs/kg

Reason for change: _____

YOUR MEDICAL INFORMATION

1. Have you ever had any indication of or been treated for conditions involving any of the following:

	Member Yes	Member 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, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine 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?	☐	☐
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, 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?	☐	☐

YOUR MEDICAL INFORMATION (continued from page 5)

	Member Yes	Member No
2. If female,		
a) are you currently pregnant?	☐	☐
If yes, give due date and the name and address of your obstetrician/gynecologist: _____		
b) What was your pre-pregnancy weight? _____lbs _____kg		
c) Have there been any complications with your pregnancy?	☐	☐
If yes, provide details: _____		
3. During the past five years, have you:		
a) Been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain sciatica, or other?	☐	☐
b) Had X-rays (including the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐	☐
c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐	☐
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	☐	☐
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	☐	☐
4. Within the past two years, have you:		
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐
b) Consulted a specialist, 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) Been currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐

If you answered yes to any of the questions on pages 3 and 4, please give details below:

Question #	Nature of Disorder	Date & Duration	Treatment (If none, state "None") & Current Status	Attending Physician or Hospital

Please note that, based on your health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

Your Family Medical History

	Member Yes	Member No
5. Have any of your parents or siblings (brothers or sisters):		
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐
b) Been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), 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:

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

8. METHOD OF PAYMENT

☐ **PAYMENT BY CHEQUE**

☐ Annual ☐ Semi-Annual

☐ **PAYMENT BY PRE-AUTHORIZED DEBIT (PAD) - MONTHLY ONLY.**

Please enclose a cheque marked "VOID".

FOR PRE-AUTHORIZED DEBIT (PAD) PAYMENT

Name of Account Holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Transit Number _____

Type of Service: ☐ Personal ☐ Business

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.

I/We authorize the distributor Sogemec Assurances inc. to make Pre-Authorized Cheque Withdrawals from my bank account for the purpose of paying premiums as they fall due. If premiums change for the policy issued for this Application, I authorize Sogemec Assurances inc. to amend the amount of pre-authorized cheque withdrawals. This payment method may be cancelled by providing 10 days written notice to Sogemec Assurances inc. or to the financial institution indicated on the Application for Insurance. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the 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 my/our bank or financial institution does not honour an automatic withdrawal the first time it is presented for payment, Sogemec Assurances inc. may attempt to withdraw that payment again within 30 days. Sogemec Assurances inc. reserves the right to ask me/us for an alternate method of payment if my/our payment is not honoured. 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/We and/or Sogemec Assurances inc. can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Sogemec Assurances inc. receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

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 1 800 361-5303, information@sogemec.qc.ca or write to us at Sogemec Assurances inc., 2, Complexe Desjardins, East Tower, 20th Floor, P.O. Box 217, Desjardins Station, Montreal, Quebec H5B 1G9.

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, you may 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) _____

Sogemec Assurances inc. is a contracted representative of The Manufacturers Life Insurance Company.

Note: Residents of Ontario add 8% Provincial Sales Tax. Residents of Quebec add 9% Provincial Sales Tax.

9. NOTICE ON EXCHANGE OF INFORMATION & NOTICE ON PRIVACY AND CONFIDENTIALITY

EXCHANGE OF INFORMATION. Information regarding your insurability will be treated as confidential. The insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, ON M5G 1R7 (www.mib.com).

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 and Sogemec 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 and Sogemec 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 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, P.O. Box 1602, Del Stn 500-4-A, Waterloo, ON N2J 4C6.

10. DECLARATION AND AUTHORIZATION (Please read carefully before signing.)

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

I declare that the statements contained in this application, including the health declaration originally attached hereto, are true and complete. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any certificate or additional coverage issued hereunder. The person to be insured understands that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I 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, the person to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licenced physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB, Inc., 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 or my health or the health of any member of my 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 authorize Manulife, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me their products or services. I understand that my consent to the use of such information to offer me products or services is optional, and that if I wish to discontinue such use, I 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 acknowledge receipt of and confirm my agreement with the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.

I (the Member) hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my death.

I declare that I 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 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 the me. I 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 health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

I acknowledge that coverage will take effect on the date the properly completed application (including my properly completed health declaration) and the first premium are received by Manulife, subject to the approval of the Company's underwriters. If I am approved, I will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am 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.

Member's Signature | Date (DD/MM/YYYY) | Signed at (City/Province)

ADVISOR'S REPORT

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent;
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your Name (first, middle initial, last)	Advisor Code	Signature
Sogemec Assurances inc.	916725	

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

For more information about these and other Engineers Canada-sponsored Plans,
visit **www.manulife.com/EngineersDI** today.

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