Manulife Financial

engineerscanada
Engineers Canada is the business name of the Canadian Council of Professional Engineers

ENGINEERS CANADA SPONSORED PLAN: 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 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

1. Member Information (If applying for Member and/or Spouse coverage)

Name of Member (PLEASE PRINT)

Last First Male ☐ Female ☐

Address City Province

Postal Code E-mail Tel. Res. ( ) Bus. ( )

Member's Date of Birth DD/MM/YYYY Country of Birth

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

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

Annual Net Income, after expenses but before tax: $ Personal Net Worth (assets less liabilities): $

2. Spouse Information (If applying for Spouse coverage)

Name of Spouse (PLEASE PRINT)

Last First Male ☐ Female ☐

Spouse's Date of Birth DD/MM/YYYY Country of Birth

E-mail Tel. Bus. ( )

Spouse's Occupation If self-employed, describe nature of business and duties.

Annual Net Income, after expenses but before tax: $ Personal Net Worth (assets less liabilities): $

3. How Much Insurance Are You Applying For?

Do not include any existing coverage. (Maximum amount of CI coverage available is $1,000,000)

Member ■ Smoker ■ Non-Smoker*

Please check one ■ box.
■ Essential 6-Condition Plan
■ Enhanced 18-Condition Plan

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

$,000
Coverage Amount

Spouse ■ Smoker ■ Non-Smoker*

Please check one ■ box.
■ Essential 6-Condition Plan
■ Enhanced 18-Condition Plan

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

$,000
Coverage Amount

** Non-Smoker rates apply to people who have not used any form of tobacco or tobacco cessation products in the last 12 months and who meet Manulife Financial's health standards.*

1. Does any applicant have any pending or existing critical illness insurance coverage with Manulife Financial or any other company?
■ Yes ■ No *If yes, complete the following:*

Name of Applicant	Company Name	Amount	Will this coverage be replaced?
		$	■ Yes ■ No
		$	■ Yes ■ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new contract.

4. Method of Payment

MEMBER _____ (Number of Units*) x _____ (Monthly Premium per Unit) = $ _____ x 0.9 (if applying for $125,000 or more) = $ _____

SPOUSE _____ (Number of Units*) x _____ (Monthly Premium per Unit) = $ _____ x 0.9 (if applying for $125,000 or more) = $ _____

*1 unit of coverage is equal to $25,000; a 10% discount applies to 5 units (5 x $25,000 = $125,000) or more. See the brochure for your monthly premium rate.

OR

☐ **MONTHLY** by Pre-Authorized Debit. Enclose a sample cheque marked "VOID."

☐ **ANNUALLY** _____ (Total Monthly Premium) + _____ (Provincial Sales Tax† (if applicable)) x 12 = $ _____ (Amount Payable)

☐ **My cheque is enclosed,** made payable to Manulife Financial ***OR***

☐ **Charge to my** ☐ MasterCard ☐ VISA Card No. | | | | | | | | | | | | | | | | Expiry Date | | | |

†Residents of Ontario add 8% Provincial Sales Tax. Residents of Québec add 9% Provincial Sales Tax.

FOR PRE-AUTHORIZED DEBIT (PAD) PAYMENT OPTIONS

Name of Account Holder _____

Financial Institution _____ Address _____ 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 Financial to withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date I/we sign this authorization. I/We authorize Manulife Financial to withdraw premiums on or about the first business day of each month or the next business day thereafter. 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 further 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 monthly withdrawal the first time it is presented for payment, Manulife Financial may attempt to withdraw that payment again within 30 days. Manulife Financial 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 Manulife Financial 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 Manulife Financial 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.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-877-598-2273, am_service@manulife.com or write to us at Manulife Financial, PO Box 670, Stn Waterloo, Waterloo, Ontario 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, you may contact your financial institution or visit www.cdnpay.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) _____

For Credit Card Payment Options

I/We hereby authorize Manulife Financial to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This Authorization may be terminated by either Manulife Financial or by me/us through written notice. Manulife Financial may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

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

5. Terms and Conditions *(Please read carefully before signing)*

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

I declare that the statements contained in this application 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 policy issued hereunder.

I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I have read and understand that exclusions and limitations apply to the coverage applied for. Suicide is a risk not covered. Relative to the insurance applied for, I, the person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the Medical Information Bureau, 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, to provide to Manulife Financial or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife Financial to consult its existing files for this purpose. I understand the insurer may request a medical examination, urinalysis or test which will be made at no expense to me and that the results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

I authorize Manulife Financial, 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 call or write to Manulife Financial at the telephone number or address shown on this document. "I" means "we" where more than one person is applying for insurance.

A photocopy or faxed copy of this authorization shall be as valid as the original.

I acknowledge receipt and confirm my agreement with the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY. (see brochure)

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. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any policy or certificate issued as a result of this application. 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.

FOR QUEBEC RESIDENTS ONLY: les parties ont expressément demandé que la présente entente et les annexes ou documents y afférents soient rédigés en anglais. The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

Insurance will take effect on the date the properly completed application (including my properly completed Health Declaration) and the first premium are received by Manulife Financial, subject to the approval of the insurer's underwriters. I understand that any health information must be accurate as at the date the application, including the Health Declaration, is signed. If I am approved, I will receive a policy specifying the coverage provided and outlining the main policy provisions. I understand that if I am not insurable, a full refund of the premiums will be made.

I/We have read and understand the Terms and Conditions and accept them.

Member's Signature _____ Signed at _____ Date DD / MM / YYYY

Spouse's Signature (if applying for Spouse coverage) _____ Signed at _____ Date DD / MM / YYYY

Representative's Name (if applicable) _____ Signed at _____ Code No. _____

Health Declaration

Please answer all questions and provide full details below or attach a separate sheet, signed and dated.
Member's and Spouse's Health Information:

Member's Full Name | Telephone Number

Member's Physician – Name | Tel. No. ( ) | Date last seen DD/MM/YYYY

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

Results and current status

Spouse's Physician – Name | Tel. No. ( ) | Date last seen DD/MM/YYYY

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

Results and current status

Member's Height ☐ ft/in ☐ cm Weight ☐ lbs ☐ kg | Spouse's Height ☐ ft/in ☐ cm Weight ☐ lbs ☐ kg

Member: Has your weight changed in the past year? ❑ Yes ❑ No If yes, ❑ Gained lb/kg ❑ Lost lb/kg Reason for change

Spouse: Has your weight changed in the past year? ❑ Yes ❑ No If yes, ❑ Gained lb/kg ❑ Lost lb/kg Reason for change

Has any individual applying for coverage:

	Member	Spouse
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including name of applicant, date, name of company and reason:	■ Yes ■ No	■ Yes ■ No
2. Within the past 5 years, had their driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), driver's licence no. and licensing province:	■ Yes ■ No	■ Yes ■ 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 name of applicant, type of activity and date(s):	■ Yes ■ No	■ Yes ■ No
4. Within the next 12 months, any intention of travelling or residing outside North America? If yes, give details including name of applicant, where, when, why and for how long:	■ Yes ■ No	■ Yes ■ No
5. 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? If yes, give details including name of applicant, drug or alcohol type(s) and date(s) last used:	■ Yes ■ No	■ Yes ■ No

See back page for additional space. **CONTINUED ON BACK**

Health Declaration *(continued)*

	Member	Spouse
6. 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), kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, thyroid nodule, skin disorder, gastrointestinal disorder, disorder of the eyes, visual disturbance, optic neuritis or other illness not mentioned?	■ Yes ■ No	■ Yes ■ No
7. Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc.), arthritis, paralysis, weakness of the extremities, numbness, tingling, loss of balance, loss of sensation, fibromyalgia or chronic pain, had x-rays of spine or joints, or been hospitalized or medically disabled for more than two consecutive weeks?	■ Yes ■ No	■ Yes ■ No
8. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?	■ Yes ■ No	■ Yes ■ No
9. 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 counselling for any disorder other than minor ailments (colds, flu, etc.), been advised to undergo further investigation, see another doctor, have surgery, have tests completed (including CT scan or MRI) or are you awaiting any test results?	■ Yes ■ No	■ Yes ■ No

IF ANY OF QUESTIONS 6 THROUGH 9 ARE ANSWERED "YES", GIVE DETAILS BELOW.

Name of Applicant	Question No.	Nature of Disorder	Date and Duration	Treatment & Current Status	Attending Physician or Hospital

	Member	Spouse
10. 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? If yes, complete the following:	■ Yes ■ No	■ Yes ■ No

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

ADDITIONAL SPACE

Questions? Call toll-free 1 877 598-2273 or e-mail us at: am_service@manulife.com

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

Underwritten by The Manufacturers Life Insurance Company