Manulife

COPA

The Association Health & Dental Plan

ZZZ

Agent ID ______________________

Agent Name ______________________

Logo ID ______________________

Health and Dental Application

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

Part A – General Information

Primary Applicant's

Last Name ______________________ First Name ______________________ Initial ________

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

Apt. Number __________ Street Number and Name ______________________

City or Town ______________________ Province ______________________ Postal Code ______________

Home Telephone ( ) ______________________ Office Telephone ( ) ______________________

Email (optional) ______________________ Occupation ______________________

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

Co-Applicant's

Last Name ______________________ First Name ______________________

Telephone ( ) ______________________ Email (optional) ______________________

Occupation ______________________

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

*All applicants must have coverage under a 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.

Are you now covered by or did you recently have employer group health insurance coverage? ☐ Yes ☐ No

If "Yes", please indicate:

Primary Applicant's

Group Plan Number ______________________ ID Number ______________________

Insurance Company ______________________ Date Benefits Ended ______________________

Co-Applicant's

Group Plan Number ______________________ ID Number ______________________

Insurance Company ______________________ Date Benefits Ended ______________________

Note for Quebec residents: Is this application intended to replace your current coverage? ☐ Yes ☐ No

If you intend to replace coverage other than your current or recently ended group health plan, do not cancel your existing coverage. Manulife may not be able to issue a policy where replacement of an existing insurance product is intended. The prescription drug coverage available under this plan is limited to costs not covered by the RAMQ Prescription Drug Insurance Plan. It is not intended to be a replacement for the RAMQ Plan. In order to be eligible for coverage under this Plan, you must have a provincial/territorial health card and be registered under the RAMQ Prescription Drug Insurance Plan, or have equivalent coverage under a group plan.

Note: When you apply for insurance, your beneficiary is set as your estate. In your welcome package, you'll find a form that you can use to change your beneficiary.

The Manufacturers Life Insurance Company

Part B – Plan Choice

Your Plan Choice applies to all family members.

I/We apply for the following Plan:

☐ Base Health and Dental Plan† ☐ Silver Health and Dental Plan ☐ Base Dental Plan† ☐ Silver Dental Plan†
☐ Bronze Health and Dental Plan ☐ Gold Health and Dental Plan ☐ Bronze Dental Plan† ☐ Gold Dental Plan†

† These plans do **not** require completion of the Medical Questionnaire of 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.

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.
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.
All applicants must complete and sign the Applicant's Authorization and Declaration.
Quebec residents may detach and mail the Medical Questionnaire portion to the insurer.
If you are detaching and mailing your The Association Health & Dental Medical Questionnaire to Manulife separately, please complete the following:

Applicant's Last Name ____________________ First Name ____________________ Initial __________

Telephone ( ) ____________________

Part D – Payment Options

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

Option #1 ☐ Pre-Authorized Debit (PAD)
Option #2 ☐ Credit Card Account

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.

Subsequent Payments will be made by:

Option #1 ☐ Pre-Authorized Debit (PAD)
PAD Billing Frequency: ☐ Monthly ☐ Semi-Annually (2% savings) ☐ Annually (4% savings)
Important: For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part E.

Option #2 ☐ Credit Card Account
Credit Card Billing Frequency: ☐ Monthly ☐ Semi-Annually ☐ Annually
Please note: Billing frequency savings are not available for credit card payment options. Please complete Part E.

Option #3 ☐ Direct Billing
Direct Billing Frequency: ☐ Semi-Annually (2% savings) ☐ Annually (4% savings)

Part E – Payment Information and Authorization

Credit Card Option Payment Information & Payment Authorization

I/We hereby authorize Manulife 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 or by me/us through written notice. Manulife 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.

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Card Number ______________________ Expiry Date (mm/yyyy) ______________

Name of Cardholder ______________________ Signature of Cardholder ______________________

Dated ______________________

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 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 onetime 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 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 1-800-268-3763, or more_info@manulife.com or write to us at Manulife, 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, 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) ______________________

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.

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

Quebec residents may detach and mail the Medical Questionnaire portion to the insurer.

Section A – Treating Qualified Health Care Practitioner

Must be completed for Bronze Health & Dental, Silver Health & Dental and Gold Health & Dental plans.

Name and telephone number of present Primary Health Care Provider/Physician (who holds the majority of your medical records) and any other Qualified Health Care Practitioners consulted **(if none, print "none"):**

Primary Health Care Provider	For Applicant	For Co-Applicant	For Dependant(s)
Name of primary health care provider			
Address of primary health care provider			
Date of last consultation			
Reason for last consultation			
Diagnosis made			
Treatment given			

Name and Telephone Number **of any other** primary health care provider consulted or referred to:

____

Name of person who consulted other Practitioner: ____

Date and reason for consultation:____

Section B – Simplified Underwriting Questionnaire

Must be completed in full for Bronze Health & Dental, Silver Health & Dental and Gold Health & Dental plans.

Have you, your co-applicant or any listed dependant(s):

1. Been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years? ☐ Yes ☐ No
2. Consulted or been advised to consult a qualified health care practitioner about or had any known indication of a medical condition or complaint within the last year? ☐ Yes ☐ No
3. Sustained any injury or been treated for any medical condition that requires or has required the services of a qualified health care practitioner at least once per year within the last 2 years? ☐ Yes ☐ No
4. a) Been advised to use a medication or treatment for a chronic and/or recurring medical condition? ☐ Yes ☐ No

   b) Used any medication or treatment for 20 or more days within the past year? ☐ Yes ☐ No

   c) Expect to use any medication or treatment within the next 3 months? ☐ Yes ☐ No

   Note: Medications used for birth control or to treat minor ailments like cold or flu are not to be considered "Yes" when answering this question.
5. Been diagnosed with any medical illness, condition or disease, or been advised by a qualified health care practitioner to have an investigation, surgery or seek hospitalization? (Do not include any minor ailments such as a cold or flu.) ☐ Yes ☐ No

If any questions in Section B are answered "Yes," please complete Section C in full.

Continued on page 5

Section C – 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.

Have you, your co-applicant or any listed dependant(s):

1. Have you, your co-applicant or any listed dependant(s) ever consulted a physician or qualified health care practitioner about, been treated for or had any known indication of: ("Yes" or "No" to all questions)

   a) High Blood Pressure, High Cholesterol or any Circulatory or Blood Disorder ☐ Yes ☐ No
   b) Heart or Blood Vessel Disorder, Heart Murmur, Chest Pain, Angina, Stroke or Transient Ischemic Attack (TIA) ☐ Yes ☐ No
   c) Back, Neck, Disc, Hip or Knee Pain or Disorder, Fibromyalgia, Osteoporosis, Osteopenia, Chronic Pain, Paralysis, Weakness or Numbness, or any other Musculoskeletal Pain or Disorder ☐ Yes ☐ No
   d) Digestive System Disorder, Crohn's Disease, Ulcerative Colitis, Liver Disease or Disorder including Hepatitis or Hepatitis Carrier State ☐ Yes ☐ No
   e) Mental, Nervous, Emotional or Neurological Disorder including Depression, Anxiety, Attention Deficit Disorder or Stress ☐ Yes ☐ No
   f) Alcohol or Drug Abuse, or any Addiction ☐ Yes ☐ No
   g) Allergies, Asthma, Bronchitis, Respiratory Disorder, Shortness of Breath or Sleep Apnea ☐ Yes ☐ No
   h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) ☐ Yes ☐ No
   i) Arthritis, Rheumatism or Rheumatoid Arthritis ☐ Yes ☐ No
   j) Cancer, Tumour, Cyst, Polyp or any Growth ☐ Yes ☐ No
   k) Skin Disorder ☐ Yes ☐ No
   l) Breast Disorder, Menopause, Reproductive Disorder, Infertility or Assisted Conception ☐ Yes ☐ No
   m) Bladder, Kidney or Prostate Disorder or other Genitourinary Disorder ☐ Yes ☐ No
   n) Headaches or Migraines ☐ Yes ☐ No
   o) Diabetes, Endocrine Disorder, Pituitary or Thyroid Disorder or Lupus ☐ Yes ☐ No
   p) Eye or Ear Disorder ☐ Yes ☐ No
   q) Any other Complaint, Condition, Disease or Disorder ☐ Yes ☐ No

   Please specify: ____

2. Have you, your co-applicant or any listed dependant(s) ever been treated for, hospitalized or had any known Physical Impairments Congenital Abnormality, Medical Condition, Injury, Disease or Disorder **not stated above**? ☐ Yes ☐ No
3. Have you, your co-applicant or any listed dependant(s) ever been advised to have an investigation, hospitalization or surgery which has **not been completed**, or are awaiting any tests or test results? ☐ Yes ☐ No
4. Have you, your co-applicant or any listed dependant(s) ever been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years? ☐ Yes ☐ No
5. If any "Yes" answers to questions 1 to 4 of Section C, please give explanation below:

Question No.	Name of Individual with Condition	Illness/Condition/ Diagnosis	Date Diag-nosed	Duration	Name and Address of qualified health care practictioner and/or Hospital Providing Treatment	Current Status of Condition

6. Are you, your co-applicant or any listed dependant(s) currently using or expecting to use in the next 3 months or have you discontinued use in the last 3 months of any drug, medication, serum or other treatment? ☐ Yes ☐ No

   If "Yes", provide details below:

Name of Individual	Name of the Drug/Medication/Se-rum/Treatment	Condition Being Treated	Strength and Daily Dosage of the Drug/Medication/Serum	Length of Time on This Drug/ Medication/Serum/Treatment

7. Are you, your co-applicant or any listed dependant(s) pregnant? ☐ Yes ☐ No

   If "Yes", Name(s) of pregnant individual(s) ______________________ Due Date (dd/mm/yyyy) __________

Notice on Privacy and Confidentiality

In this Statement, "you" and "your" refer to the plan member or holder of rights under the contract , the insured and the parent or guardian of any child named as insured who is under the legal age for providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?
Depending on the product you have applied for, 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, or driver's license
- Medical information that any organization or person has about you
- A copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or a consumer report from other organizations, person or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographicsand interests
- Banking data to administer benefits
- Other personal information we may require to administer our business relationship with you

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

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company,
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your plan now, and in the future
  - Public sources, such as government agencies, and internet sites
  - Health Care Professionals, including Medical Practitioners, health care institutions, pharmacy and any other medically-related facility
  - Other insurance carriers
  - Administrators of government benefits and other benefit programs

What do we use your personal information for?
We will use your personal information to:

- help us properly 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, and issue and administer the rights under the plan
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons and other parties with whom we deal in issuing and administering your plan now, and in the future
- Authorized employees, agents and representatives
- 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 medical doctor

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be 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.

How long do we keep your information?
The longer of:

- the time period required by law and by guidelines set for the financial services industry, and
- the time period required to administer the products and services we provide.

Withdrawing your consent
You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the plan unless federal or provincial laws give you this right. If you do so, a plan may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

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 and Access
You will notify us of any change to your contact information. 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. If you have a question, a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
500 King Street N
P.O. Box 1602
Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you 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 Notice on Privacy and Confidentiality.

I/We understand and agree that coverage shall not become effective until the first of the month following final approval and receipt of first premium payment.

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

Signed at ______________________ Signature of Primary Applicant ______________________ Dated (dd/mm/yyyy) __________
(City, Province)

Signed at ______________________ Signature of Co-Applicant ______________________ Dated (dd/mm/yyyy) __________
(City, Province)

Advisor's Report – For Advisor/Agent Use Only

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) ______________________________

Agent ID ______________________ Signature______________________

Please send the completed application to:

Regular Mail:

Manulife
P.O. Box 670
Stn Waterloo
Waterloo, ON N2J 4B8

Courier:

Manulife
500 King Street
Affinity Markets New Business
Delivery Station 500-GB
Waterloo, ON N2J 4C6

Fax

1-888-264-2243

The Association Health & Dental Plan is offered through The Manufacturers Life Insurance Company (Manulife).

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

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