Manulife Financial

Group Benefits
Personal Critical Illness Application

Conditions for eligibility

By signing the Authorization section of this Application on page 8 of 9, I signify my understanding and acknowledgement that in order to qualify for coverage in amounts of $25,000 or less that do not require the completion of a detailed medical questionnaire, the person(s) whom I seek to insure under this application (myself, my spouse, my child(ren) or any one of us) must be in good health ("Good Health"), and accordingly, I **declare** that the person(s) whom I seek to insure is (are) in Good Health and more specifically, that any adult(s) to be insured does (do) not have any physical or mental conditions that prevent them:

(a) if they are employed, from regularly attending to their occupation, or

(b) if they are not employed, from being so employed if they chose to engage in an occupation; and

that the person(s) whom I seek to insure has (have) never been declined when they have either applied for or been the subject of any application for life insurance or critical illness insurance coverage with any insurer, or other entity. I also **understand and acknowledge** that where this application is approved by Manulife Financial, the contract issued to me will contain an exclusion under which benefits will not be paid for any pre-existing medical conditions, as defined in the contract.

Instructions:

1. Please consult your plan administrator for the policy number and certificate number, if applicable.
2. Please print in ink.
3. **Please retain a photocopy for your files.**

1a) Plan member information

Required if applying for member, spousal or child coverage

Policy number(s)	Plan member certificate number

Plan sponsor/employer name

Plan member name (first, middle initial, last)

Sex	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
◯ Male ◯ Female		( )	( )

Email address (optional)	Plan member's address (street number, street and apartment)

City	Province	Postal code

1b) Personal critical illness amount

Required if applying for member coverage

Available in multiples of $5,000 with a minimum $10,000 up to $150,000.

Are you applying for the first time? ◯ Yes ◯ No

If *yes*, amount requested $_____

If *no*, additional amount requested $_____

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

2 Spousal information

Only required if applying for spousal coverage

Spouse's name (first, middle initial, last)	Sex	Date of birth (dd/mmm/yyyy)
	◯ Male ◯ Female	

Spousal critical illness amount

Available in multiples of $5,000 with a minimum $10,000 up to $150,000.

Are you applying for the first time? ◯ Yes ◯ No

If *yes*, amount requested $_____

If *no*, additional amount requested $_____

Have you smoked (cigarettes, cigars, pipe, etc) or used tobacco in any other forms or any smoking cessation aids within the last 12 months? ◯ Yes ◯ No

3 Child information

Only required if applying for coverage for child(ren)

Child critical illness amount:

◯ $10,000 benefit applies to all eligible dependent children under age 21.

Provide details for all children under age 21.

Name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)	Sex
		◯ Male ◯ Female
		◯ Male ◯ Female
		◯ Male ◯ Female
		◯ Male ◯ Female