Manulife Financial

Group Benefits
Personal Critical Illness Evidence of Insurability

Complete only if applying for a total coverage amount over $25,000.

The following questions should be answered by each individual applying for coverage that needs to provide evidence of insurability as part of your application. If more space is needed, use another form or sheet of paper (both must be signed and dated).

For Manulife Financial use

Policy number(s)	Plan member certificate number

Plan member name (first, middle initial, last)	Member: ◯ Smoker ◯ Non-smoker	Spouse: ◯ Smoker ◯ Non-smoker

1 a) Plan member basic medical information

Only required if applying for total coverage over $25,000

Height	Weight	Any weight change greater than 10 pounds in the last 12 months?
________ m ________ cm ________ ft ________ in	◯ kg ◯ lb	◯ No ◯ Yes Gain/loss __________ ◯ kg ◯ lb Reason: ________

Name of personal physician (first, middle initial, last)	Physician's phone number
	( )

Date of last visit (dd/mmm/yyyy)	Reason

Address of personal physician (street number, street and suite)

City	Province	Postal code

1 b) Spouse basic medical information

Only required if applying for total spousal coverage over $25,000

Height	Weight	Any weight change greater than 10 pounds in the last 12 months?
________ m ________ cm ________ ft ________ in	◯ kg ◯ lb	◯ No ◯ Yes Gain/loss __________ ◯ kg ◯ lb Reason: ________

Name of personal physician (first, middle initial, last)	Physician's phone number
	( )

Date of last visit (dd/mmm/yyyy)	Reason

Address of personal physician (street number, street and suite)

City	Province	Postal code

2 Medical questionnaire

	Plan member	Spouse
A. **Have you ever had an application for any insurance that was declined, postponed or rated in any way?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Reason

	Plan member	Spouse
B. **Have you ever been diagnosed with, had any known indication of, had a positive test for, consulted a physician about, suffered from, received medication, medical advice, treatment, care or been advised to receive care or have further treatment for:**		
1) AIDS, a positive HIV test or AIDS-related disease?	◯ Yes ◯ No	◯ Yes ◯ No
2) Diabetes?	◯ Yes ◯ No	◯ Yes ◯ No
3) Multiple sclerosis?	◯ Yes ◯ No	◯ Yes ◯ No
4) Organ transplant?	◯ Yes ◯ No	◯ Yes ◯ No
5) Hepatitis or hepatitis carrier state, other than Hep A?	◯ Yes ◯ No	◯ Yes ◯ No
6) Stroke or transient ischemic attack (TIA)?	◯ Yes ◯ No	◯ Yes ◯ No
7) Alzheimer's disease or Parkinson's disease?	◯ Yes ◯ No	◯ Yes ◯ No

2 Medical questionnaire (continued)

	Plan member	Spouse
8) Kidney disease (excluding kidney stones or an acute kidney infection with full recovery)?	◯ Yes ◯ No	◯ Yes ◯ No
9) Motor neuron diseases, including but not limited to Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)?	◯ Yes ◯ No	◯ Yes ◯ No
10) Heart disease, including heart attack, angina, valvular surgery or disease, coronary bypass surgery or angioplasty, congestive heart failure, arrhythmia, peripheral vascular disease, or aneurysm?	◯ Yes ◯ No	◯ Yes ◯ No
11) Paralysis? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Is it trauma related? ◯ Yes ◯ No	◯ Local or ◯ General paralysis

Details

	Plan member	Spouse
12) Chest pain? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause

Diagnosis	Status

Treatment

	Plan member	Spouse
13) Congenital heart disorder? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause

Diagnosis	Status

Treatment

	Plan member	Spouse
14) Heart murmur, shortness of breath, irregular heart beat, any disorder of the blood? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Cause

Diagnosis	Status

Treatment

	Plan member	Spouse
15) Lymph, glandular disorder, or thyroid disorder? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)

Diagnosis	Status

Treatment

	Plan member	Spouse
16) Disorder of the eye or ear leading to blindness or deafness? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)

Diagnosis	Status

Treatment

	Plan member	Spouse
17) Alcohol or drug abuse? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy) and duration

Treatment and results

2 Medical questionnaire (continued)

	Plan member	Spouse
18) Disorder of the brain or nervous system, neurological disorder, epilepsy, optic neuritis, blurred or double vision, memory loss, weakness, tremor, numbness or tingling, impaired balance, loss of consciousness? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date of onset (dd/mmm/yyyy)	Date of last symptoms (dd/mmm/yyyy)

Diagnosis	Status

Treatment

Name and address of doctor seen

	Plan member	Spouse
19) Cancer, leukemia, Hodgkin's disease or other malignancy?	◯ Yes ◯ No	◯ Yes ◯ No
20) Growths, cysts or tumour? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Type

Location on body	Status
	◯ Benign ◯ Malignant

Treatment

	Plan member	Spouse
21) Dysplastic nevi or moles? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)	Type

Location on body	Status
	◯ Benign ◯ Malignant

Treatment

	Plan member	Spouse
22) Any disorder of the lung, kidney, bladder, breast, prostate, gastro-intestinal tract or reproductive organs? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date of onset (dd/mmm/yyyy)	Date of last symptoms (dd/mmm/yyyy)

Diagnosis	Status

Treatment

Name and address of doctor seen

	Plan member	Spouse
C. 1) **Have any of your immediate family members (parents, sisters, brothers) been diagnosed with cancer, heart disease, chronic kidney disease, angina, stroke, multiple sclerosis, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) or motor neuron disease prior to age 60?** If answered yes, please provide details in the chart below.	◯ Yes ◯ No	◯ Yes ◯ No

Member or spouse's family member	Name of family member	Relationship	Condition	Age at onset	Age at death (if applicable)
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					
◯ Member ◯ Spouse					

2 Medical questionnaire (continued)

	Plan member	Spouse
2) If you have a family history of breast or ovarian cancer, have you had a breast exam, mammogram or other investigation? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)

Results

	Plan member	Spouse
3) If you have a family history of colon cancer, have you had a colonoscopy? If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)

Results

	Plan member	Spouse
D. **During the last 5 years, have you had any abnormal result of any of the following: EKG, stress EKG, echocardiograms, mammogram, Pap smear (exclude if 2 subsequent Pap smears have been normal), PSA, sigmoidoscopy, colonoscopy, biopsy?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Test type	Date (dd/mmm/yyyy)

Test results	Status

Treatment

	Plan member	Spouse
E. **Other than for a common cold, osteoarthritis, bone fractures, have you had an abnormal result of any of the following: X-ray, CAT scan, or MRI?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Test type	Date (dd/mmm/yyyy)

Test results	Status

	Plan member	Spouse
F. **Have you ever had elevated blood pressure or cholesterol?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person	Date (dd/mmm/yyyy)

Most recent results	Is it under control?

Treatment

	Plan member	Spouse
G. **Are you aware of any symptoms or complaints for which you have not sought treatment or advice, or are you awaiting any tests or test results?** If answered yes, please provide details.	◯ Yes ◯ No	◯ Yes ◯ No

Name of person

Details