



# HEALTH AND DENTAL PLAN APPLICATION

**Manulife Financial**  
For your future™

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- **All Applicants** must complete **Parts A, B, C, D** and **E**.
- **All Applicants** must sign and complete **"Applicant's Declaration"** on Page 6.
- If you require additional space to complete any part of this application, please attach a separate sheet.

FOR MANULIFE FINANCIAL USE ONLY
KEYED _____
APPROVED _____

<b>Centre:</b>
<b>Agent ID:</b> CA400
<b>Logo ID:</b> CASK

## Part A • General Information

Applicant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Apt. Number \_\_\_\_\_ Street Number and Name \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_  
 City or Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Occupation \_\_\_\_\_

CAA Membership Number  

6	2	0	2	8	6														
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Government Health Card Number  

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Applicant's Office Telephone ( ) \_\_\_\_\_ Co-Applicant's Office Telephone ( ) \_\_\_\_\_  
 Applicant's Fax ( ) \_\_\_\_\_ Co-Applicant's Fax ( ) \_\_\_\_\_  
 Applicant's E-mail \_\_\_\_\_ Co-Applicant's E-mail \_\_\_\_\_

If additional information is required during regular business hours, how may we contact you?  Home  Office  E-mail  
 Are you now covered or did you have previous coverage with Manulife Financial or any other insurance company?  Yes  No If "yes," please indicate:  
 Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_ Insurance Company \_\_\_\_\_ Date Benefits Ended \_\_\_\_\_ (DD/MM/YYYY)  
 Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_ Insurance Company \_\_\_\_\_ Date Benefits Ended \_\_\_\_\_ (DD/MM/YYYY)

Is this application intended to replace your current coverage?  Yes  No

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

**Applicant's Beneficiary:**  
 Name \_\_\_\_\_  
 Relationship to Applicant \_\_\_\_\_  
 Signature of Applicant \_\_\_\_\_  
 Date \_\_\_\_\_ (DD/MM/YYYY)

**Co-Applicant's Beneficiary:**  
 Name \_\_\_\_\_  
 Relationship to Co-Applicant \_\_\_\_\_  
 Signature of Co-Applicant \_\_\_\_\_  
 Date \_\_\_\_\_ (DD/MM/YYYY)

If you designate a beneficiary under the age of 18, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed.  
 Name of Trustee \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
 Name of Trustee \_\_\_\_\_ Relationship to Co-Applicant \_\_\_\_\_  
 Signature of Applicant \_\_\_\_\_ Signature of Co-Applicant \_\_\_\_\_  
 Date \_\_\_\_\_ (DD/MM/YYYY) Date \_\_\_\_\_ (DD/MM/YYYY)

Questions? Call 1-866-999-4222



## Part E • Payment Information and Authorization

### PAYMENT INFORMATION

#### 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, 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 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 alternative method of payment if 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 or Manulife Financial 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 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](http://www.cdnpay.ca). If you have any questions about withdrawals from your bank account, contact us at 1 866-999-4222 or [am\\_caa@manulife.com](mailto:am_caa@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, contact your financial institution or visit [www.cdnpay.ca](http://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

# 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 on the first day of the month following approval of this application.

If applying for Drug 2 or Drug 3 Plan, you must complete Sections A, B and Applicant's Declaration on Page 6. If any of the questions in Section B are answered "yes," Sections C and D must be completed. ALL Applicants must complete Applicant's Declaration on Page 6.

## Section A • Treating Qualified Health Care Practitioner

Name and Address 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 the Applicant	For the Co-Applicant	For the Dependant(s)
Name of Primary Health Care Provider:			
Address of Primary Health Care Provider:			
<b>Last Consultation</b> - Date:			
- Reason:			
- Diagnosis Made:			
- Treatment Given:			

Name and address of any other Qualified Health Care Practitioner consulted:

\_\_\_\_\_

Name of person who consulted other Practitioner: \_\_\_\_\_

Date and reason for consultation: \_\_\_\_\_

Note: Additional medical information may be required to underwrite your application.

## Section B • Simplified Questionnaire

**Must be completed if you are selecting Drug 2 or Drug 3 Plan.**

Have you, your Co-Applicant or any listed dependant:

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 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 major medical illness, condition or disease, or been advised by a Qualified Health Care Practitioner to have an investigation, surgery or seek hospitalization?  Yes  No

Note: Additional medical information may be required to underwrite your application.

**If any questions above are answered "yes," please complete Sections C and D.**

## Section C • Medical Conditions

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: Check (✓) Yes or No for all questions.

- |   |  |
|---|--|
| a) High Blood Pressure, Stroke, T.I.A. or Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b) Heart, High Cholesterol or Circulatory Disorder, Dizziness, Fainting or Blood Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>c) Back, Joint or any Musculoskeletal Pain or Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>d) Digestive System Disorder, Liver Disease/Disorder including Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No<br>e) Nervous, Mental, Emotional or Stress Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>f) Alcohol/Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No<br>g) Asthma/Allergies/Respiratory Disorder or Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No<br>h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV) <input type="checkbox"/> Yes <input type="checkbox"/> No | i) Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No<br>j) Cancer, Tumour or any Growth <input type="checkbox"/> Yes <input type="checkbox"/> No<br>k) Skin Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>l) Infertility/Reproductive Disorder/Menopause <input type="checkbox"/> Yes <input type="checkbox"/> No<br>m) Bladder/Kidney Disorder or other Genitourinary Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>n) Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No<br>o) Diabetes/Endocrine Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>p) Eye or Ear Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>q) Other Condition/Disease/Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Please specify: _____<br>_____ |
|---|--|

2. Have you, your Co-Applicant or any listed dependant(s) ever been treated for, hospitalized for or had any Physical Impairment, Congenital Abnormality, Medical Condition, Disease or Disorder not stated above?    Applicant  Yes  No    Co-Applicant  Yes  No    Dependent Child  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?    Applicant  Yes  No    Co-Applicant  Yes  No    Dependent Child  Yes  No

If answer is "yes" to any question in Section C, give explanation below:

Question No.	Proposed Insured with Condition	Name of Illness/Condition	Date Diagnosed	Duration	Name & Address of Qualified Health Care Practitioner and/or Hospital Providing Treatment	Results of Treatment & Extent of Recovery

## Section D • Medications and Treatments

1. Are you, your Co-Applicant or any listed dependant(s) currently using or expecting to use in the next 3 months any drug, medication, serum or other treatment?  Yes  No    If "yes," provide details below:

Proposed Insured	Name of the Drug/ Medication/Serum/Treatment	Condition Being Treated	Strength & Daily Dosage of the Drug/Medication/Serum	Monthly Cost	Length of Time on this Drug/Medication/Serum/Treatment

2. Are you, your Co-Applicant or any listed dependant(s) pregnant?  Yes  No    If "yes," name: \_\_\_\_\_ Due date: \_\_\_\_\_ (DD/MM/YYYY)

**Note: Additional medical information may be required to underwrite your application.**

## Applicant's Declaration • All Applicants Must Complete This Section

**This plan is underwritten by The Manufacturers Life Insurance Company.**

- Check here if you do not wish to receive further information and material on Manulife Financial's products.

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 Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial 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 or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. Manulife Financial 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 the Notice on Privacy and Confidentiality as stated in the brochure. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Co-Applicant

DATED \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

**Questions? Call 1-866-999-4222**

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