11804 001 WSFXL

Advisor ID: 00245B

Lifecheque® Basic Critical Illness Insurance Application Form

Advisor Name: HealthQuotes.ca

Advisor Email:

Applicant Information – Must be a Canadian Resident

Please contact me at: ☐ Home ☐ Business ☐ Email

Last Name _____

First Name _____ Initial _____

Address _____

City _____ Province _____ Postal Code _____

Email _____

Date of Birth _____ DD / MM / YYYY ☐ Male ☐ Female

Home Telephone ( ) _____ Business Telephone ( ) _____

Choice of Coverage

Amount of coverage applying for:
(Please select ☑ one)

☐ $25,000 ☐ $50,000 ☐ $75,000

With Return of Premium Option
(Available for ages 18 to 55)

☐ Yes ☐ No

I confirm my smoking status as:
(Please select ☑ one)

☐ Smoker ☐ Non-Smoker*

*A non-smoker is defined as a person who has not used any tobacco, nicotine substitutes, tobacco cessation products or marijuana within the last 12 months.

Payment Options – Pay monthly by PAC or credit card

PAYMENTS will be made by:

Option #1 ☐ Pre-Authorized Monthly Collection (PAC) plan from my Financial Services Account
Important: Please enclose a sample cheque marked "VOID".

Option #2 ☐ Credit Card Account
Credit Card Billing Frequency: ☐ Monthly ☐ Annually

Payment Information and Authorization

For Pre-Authorized Collection (PAC) Options

Name of Account holder (if other than Applicant) _____

Financial Institution _____

Type of Account: ☐ Chequing ☐ Non-Chequing

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 the authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payment 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 Credit Card Payment Options

Credit Card: ☐ Visa ☐ MasterCard ☐ Amex

Account Number: _____ Expiry Date: _____ MM / YY

Name of Account holder (if other than Applicant) _____

Payment Authorization

For Pre-Authorized Collection and Credit Card billing 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.

_____ Signature of Cardholder or Account holder

_____ Second signature if joint account

Please complete both sides >

Health Declaration – Please read carefully before signing

I declare that I am a Canadian resident. I understand that my coverage will come into effect on the first day of the month following the date my application is received and approved by Manulife Financial.

I declare that during the past 10 years I have not been diagnosed with, had any signs and/or symptoms of, or had any medical consultations and/or abnormal tests for the following disorders:

- Cancer, Intracranial Tumour
- Heart Disease (including but not limited to Angina and Heart Attack), Stroke, Transient Ischemic Attack (TIA),Peripheral Vascular Disease or Diabetes
- Hepatitis, including Hepatitis Carrier State, Chronic Kidney Disease, AIDS or HIV
- Alcoholism or Drug Abuse

I declare that I have not had, during the last 10 years, Coronary Artery Bypass surgery and/or Aortic surgery.

I also declare that I have not undergone any tests for which I am currently awaiting results and I have not been advised to undergo any tests which have not yet been completed.

I agree that any material misrepresentation, including smoking status, will render the insurance voidable by Manulife Financial at any time.

I acknowledge receipt of and agree with the Notice on Privacy and Confidentiality.

Signed at: _____ Date: DD / MM / YYYY Applicant's Signature _____

Advisor's Report – For Advisor 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) HealthQuotes.ca Advisor code 00245B

Signature _____

List the advisors involved in this sale. Note: the first advisor listed will be considered the servicing advisor.

Name of **servicing** advisor _____ Advisor code _____ Percentage of commission _____%

☐ Name of advisor _____ Advisor code _____ Percentage of commission _____%

Distribution channel:

Managing General Agency (MGA)

Name _____ MGA code _____ MGA email _____

National Account

Name _____ National Accounts code _____ National Accounts email _____

Note: If you are contracted through a MGA/National Account firm, please forward the completed application to their office.

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions .

Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 2 Queen Street East, Toronto, Ontario M5W 5M3.

Lifecheque Basic Critical Illness Insurance is offered through Manulife Financial (The Manufacturers Life Insurance Company).

Manulife Financial

If you have any questions or need help completing this form please call toll free at 1-800-474-4474

- For the fastest possible coverage please fax your application -

Mail To:
Individual Health Applications,
64 Temperance St.
Aurora, ON
L4G 2P8

Fax To:
Individual Health Applications,
1-866-676-4581
(If the faxed application is not clear you may have to mail in the original. If using pre-authorized payment then you must also fax us a copy of a void cheque. For assistance please call us).