APPLICATION FOR CIC GROUP INSURANCE PLANS

Chemical Institute of Canada

Manulife Financial
For your future™

ELIGIBILITY:

To apply for Member coverage, you must be a Member in good standing of The Chemical Institute of Canada.

All persons to be insured must be resident in Canada and under 61 years of age.

1. About You

☐ Male ☐ Female

Last Name | First Name | Initial

Address

City | Province | Postal Code

Date of Birth (DD/MM/YYYY) | Country of Birth

Tel. (Home) | Tel. (Bus.)

E-mail

Occupation

Self-employed? ☐ Yes ☐ No If yes, please describe the nature of your business and duties in the space provided below.

2. About Your Spouse

☐ Male ☐ Female

(Complete only if applying for Spouse coverage.)

Last Name | First Name | Initial

Date of Birth (DD/MM/YYYY) | Country of Birth

Tel. (Bus.)

E-mail

Occupation

Self-employed? ☐ Yes ☐ No If yes, please describe the nature of your business and duties in the space provided below.

CIC-App-W (06/13)

3. Child(ren) Information *(Complete only if applying for Child coverage.)*

Name of Child	Gender	Date of Birth	Height	Weight	Name, Address and Telephone Number of Family Doctor
	☐ M ☐ F	DD/MM/YYYY	☐ ft/in ☐ cm	☐ lbs ☐ kg	
	☐ M ☐ F	DD/MM/YYYY	☐ ft/in ☐ cm	☐ lbs ☐ kg	
	☐ M ☐ F	DD/MM/YYYY	☐ ft/in ☐ cm	☐ lbs ☐ kg	

If more space is needed, complete a separate sheet, signed and dated.

4. Your Coverage Choices

I am applying for ☐ New coverage. ☐ Additional coverage. If currently insured under these plans, list Policy/Certificate No. _____

If applying for additional coverage, DO NOT INCLUDE COVERAGE ALREADY IN FORCE.

Member: ☐ Smoker ☐ Non-Smoker[1] **Spouse: ☐ Smoker ☐ Non-Smoker**[1]

[1] Non-Smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife Financial's health standards.

TERM LIFE INSURANCE[2]

Member

Amount of coverage applied for

$ _____

Available from $25,000 to $750,000 in increments of $25,000.

Spouse *(Available only with the Member Term Life Plan)*

Amount of coverage applied for

$ _____

Available from $25,000 to $750,000 in increments of $25,000.

[2] Manulife Financial reserves the right to request additional medical information in order to assess your application and also reserves the right to accept or decline applications.

CHILD LIFE AND ACCIDENT INSURANCE *(Available only with the Member Term Life Plan)*

One monthly premium of $1.00 covers ALL of your eligible children for $5,000 of life coverage each. ☐ Yes ☐ No

(Your Coverage Choices continued on next page)

4. Your Coverage Choices *(Continued)*

PERSONAL ACCIDENT INSURANCE *(Available only with the Member Term Life Plan)*

The monthly premium is $1.25 for each increment of $25,000.

Member

Available from $25,000 to $750,000 in increments of $25,000 .....

Amount of Coverage ☐

Spouse

Available from $25,000 to $750,000 in increments of $25,000 .....

Amount of Coverage ☐

MEMBER INCOME PROTECTION PLUS

Waiting period	**Amount of coverage applied for**	Optional Cost-of-Living Adjustment
☐ 30 days ☐ 120 days ☐ 180 days	$ _____ / month Available from $500 to $5,000/month in increments of $100	☐ Under age 45 ($0.25 per unit of $100) ☐ Age 45 to 64 ($0.55 per unit of $100)

Complete this section when applying for Income Protection PLUS *(Member only)*

1. If self-employed, what is the organizational structure of your business? ☐ Sole Proprietor ☐ Partnership ☐ Corporation
2. If owner of a partnership or corporation, give percentage ownership: _____ %
3. Date you became self-employed (DD/MM/YYYY): _____
4. Have you declared or are you contemplating personal or business bankruptcy? ☐ Yes ☐ No If yes, provide details including date of discharge:

_____

Proof of Income: If applying for more than $3,500/month, please submit pages 1, 2 and 3 of your last 2 years' tax returns. If incorporated, please also submit your last corporate financial statement.

5. Financial Information

(Complete only if applying for more than $250,000 of applied for and existing Term Life coverage or if applying for Income Protection PLUS.)

Member Your Annual Net Earned Income	**Spouse** Your Annual Net Earned Income
(after business expenses but before tax) $_____	(after business expenses but before tax) $_____
Personal Net Worth (assets less liabilities) $_____	Personal Net Worth (assets less liabilities) $_____

6. Other Insurance Information

Do you (Member or Spouse) have any existing insurance coverage with Manulife Financial or any other company? ☐ Yes ☐ No If yes, please complete the following:

Name of Applicant	Company Name	Type of Insurance (life, disability)	Amount	Elimination Period (for disability)	Benefit Period (for disability)	Non-taxable or taxable? (for disability)	Do you intend to replace this coverage?
			$				☐ Yes ☐ No
			$				☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until your application is approved and you receive your new insurance contract. A replacement form or declaration may be required and we may not be able to issue an insurance contract where replacement is indicated.

7. Beneficiary(ies) Designation

Beneficiary(ies) for Member Coverage *(If designating more than one beneficiary, please attach an additional sheet, signed and dated.)*

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary(ies):

Last Name _____ First Name _____

Relationship_____ % of Benefit _____

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; except in Quebec, where benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee for Minor Child:

Last Name _____ First Name _____

Relationship _____

For Quebec residents only:

In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

Beneficiary(ies) for Spouse Coverage *(If designating more than one beneficiary, please attach an additional sheet, signed and dated.)*

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary(ies):

Last Name _____ First Name _____

Relationship_____ % of Benefit _____

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; except in Quebec, where benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

Trustee for Minor Child:

Last Name _____ First Name _____

Relationship _____

For Quebec residents only:

In the province of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

8. Underwriting Questionnaire *(The entire Questionnaire must be completed, even if all health questions are answered "NO.")*

This application is not valid unless the Underwriting Questionnaire is fully completed and the application is signed.

Québec residents only: After completion you **may** detach this section and send it directly to Manulife Financial at the address shown on this document.

Member's Last Name	First Name
Member's E-mail Address	Home Telephone
Member's Physician (Name)	Telephone
Physician's Address	
Reason Last Seen	Date Last Seen
Tests, Treatment, Medication Prescribed (if none, state "None")	
Results and Current Status	
Member's Height ☐ ft/in ☐ cm	Member's Weight ☐ lbs ☐ kg
Has your weight changed in the past year? ☐ Yes ☐ No	☐ Gained ☐ Lost ☐ lbs ☐ kg
If Yes, Reason for Weight Change	

Spouse's Last Name	First Name
Spouse's E-mail Address	
Spouse's Physician (Name)	Telephone
Physician's Address	
Reason Last Seen	Date Last Seen
Tests, Treatment, Medication Prescribed (if none, state "None")	
Results and Current Status	
Spouse's Height ☐ ft/in ☐ cm	Spouse's Weight ☐ lbs ☐ kg
Has Spouse's weight changed in the past year? ☐ Yes ☐ No	☐ Gained ☐ Lost ☐ lbs ☐ kg
If Yes, Reason for Weight Change	

Has any individual proposed for coverage (Member, Spouse or child(ren)):	**MEMBER**		**SPOUSE**		**CHILD(REN)**	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including name of applicant, date, name of company and reason: _____	☐	☐	☐	☐	☐	☐
2. Within the past 5 years, had their driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), driver's licence no. and licensing province: _____	☐	☐	☐	☐	☐	☐
3. Any intention of piloting an aircraft or participating in scuba-diving, parachuting, hang-gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including name of applicant, type of activity and date(s):	☐	☐	☐	☐	☐	☐
4. Within the next 12 months, any intention of travelling or residing outside North America? If yes, give details including name of applicant, where, when, why and for how long: _____	☐	☐	☐	☐	☐	☐
5. Within the past 7 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? If yes, give details including name of applicant, drug or alcohol type(s) and date(s) last used:	☐	☐	☐	☐	☐	☐
6. Female Members only: a) Are you currently pregnant? If yes, give due date: _____	☐	☐				
b) Have you ever had a miscarriage, pre-eclampsia, Caesarean section or other complication of pregnancy? If yes, give date and details: _____	☐	☐				
7. Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress, etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned?	☐	☐	☐	☐	☐	☐
8. Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc.), arthritis, paralysis or weakness, fibromyalgia or chronic pain, had X-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks?	☐	☐	☐	☐	☐	☐
9. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?	☐	☐	☐	☐	☐	☐

8. Underwriting Questionnaire *(Continued)*

Has any individual proposed for coverage (Member, Spouse or child(ren)):

	MEMBER		SPOUSE		CHILD(REN)	
	YES	NO	YES	NO	YES	NO
10. Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.), or been advised to undergo further investigation, see another doctor or have surgery?	☐	☐	☐	☐	☐	☐

If you answered "yes" to any of Questions 7 through 10 above, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question No.	Name of Proposed Insured	Nature of Disorder	Date and Duration	Treatment and Current Status	Attending Physician or Hospital

	MEMBER		SPOUSE		CHILD(REN)	
	YES	NO	YES	NO	YES	NO
11. a) Have any of your parents or siblings (brothers or sisters) been diagnosed **prior to age 60** with heart disease, stroke or cancer?	☐	☐	☐	☐	☐	☐
b) Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, retinitis pigmentosa or any hereditary disease?	☐	☐	☐	☐	☐	☐

If yes to a) or b) above, please complete the following:

Name of Proposed Insured	Family Member	Condition (If cancer, specify type)	Age at Onset	Age at Death and Cause, if applicable

The Insurer may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV), which will be made at no expense to the Member. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

9. Method of Payment

☐ **MONTHLY OR** ☐ **ANNUAL**

☐ A. Pre-Authorized Debit (PAD) (**Please enclose a cheque marked "VOID".**)

☐ B. Credit Card (choose one) ☐ MasterCard ☐ Visa

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date (MM/YYYY) _____ MM/YYYY

(Once your coverage is approved, we will add the applicable taxes to your payment – 8% Retail Sales Tax for Ontario residents; 8% Retail Sales Tax for Manitoba residents; 9% Sales Tax for Quebec residents.)

☐ **ANNUAL BY CHEQUE**

Payable to Manulife Financial in the amount below:

$_____ (Total Monthly Premium) X _____ (No. of months to May 1st (excluding current month)) X 1.08 in Ontario (PST) 1.09 in Quebec (TVQ) 1.08 in Manitoba (RST) = $_____ (Amount Payable)

Payment Authorization 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) _____

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 and may change in accordance with the insurance contract and as required to administer the 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 alternate method of payment if my/our 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 and/or Manulife Financial can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a 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. If you have any questions about withdrawals from your bank account, contact us at 1-800-668-0195, am_service@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, you may contact your financial institution or visit 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) _____

10. 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 or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, ON M5W 5M3.

11. Notice on Exchange of Information

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7.

12. Declaration & Authorization *(Please read carefully before signing.)*

DECLARATION: I/We hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/We declare that the statements contained in this application, including but not limited to the Underwriting Questionnaire originally attached hereto, 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 or certificate issued hereunder. I/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date for life insurance is a risk not covered. I/We understand that insurance will take effect on the date my/our properly completed application (including the Underwriting Questionnaire) and the first premium are received by Manulife Financial, subject to the approval of the Company's underwriters. I/We understand that any health information must be accurate as at the date the application is signed.

AUTHORIZATION AND REVOCATION: Relative to the insurance applied for, I/we, the undersigned person(s) to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB, Inc., the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency, or other organization, institution or person that has any records or knowledge of me/us, or of our health, to give Manulife Financial or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I/We authorize Manulife Financial to consult its existing files for this purpose. I/We authorize Manulife Financial, its subsidiaries, affiliates and agents to use this information to offer me/us their products and services. I/We understand that my/our consent to the use of this information to offer me/us products or services is optional and that if I/we wish to discontinue such use, I/we may call or write to Manulife Financial at the address or telephone number shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/We acknowledge receipt of, and confirm my/our agreement with, the Notice on Exchange of Information and the Notice on Privacy and Confidentiality. I/We declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any policy or certificate issued as a result of this application. I/We understand that this consent may be revoked at any time and that if as a result of such revocation the Insurer is unable to obtain proof of claim, this may result in claims not being paid.

I (the Member) hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any policy or certificate issued hereunder.

For Québec residents:

☐ Les parties ont expressément demandé que la présente entente et les annexes ou documents y afférents soient rédigés en anglais. The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

Member's Signature	Signed at (City/Town, Province)	Date (DD/MM/YYYY)
Spouse's Signature (If applying for Spouse coverage)	Signed at (City/Town, Province)	Date (DD/MM/YYYY)
Representative's Name (If applicable)	Code #	Date (DD/MM/YYYY)

Underwritten by The Manufacturers Life Insurance Company (Manulife Financial).

QUESTIONS? CALL MANULIFE FINANCIAL, TOLL-FREE: **1-800-668-0195**
or visit **manulife.com/CIC** or e-mail: **am_service@manulife.com**.

PLEASE SEND YOUR COMPLETED APPLICATION, ALONG WITH PAYMENT, TO:
Manulife Financial, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8