

PRE-SCREEN QUESTIONNAIRE

Before applying for Critical Illness Insurance, it is important to understand that this plan is not available to you if you or your spouse (if applying) have had any of the following conditions or procedures:

Active hepatitis	Cancer – all cancer except basal cell skin cancer	Kidney disease – other than kidney stones or a history of kidney infection	Multiple sclerosis
AIDS or AIDS-related disease	Coronary bypass surgery	Lou Gehrig's disease – amyotrophic lateral sclerosis (ALS)	Permanent paralysis (paraplegia, quadriplegia) – other than Bell's palsy
Alcohol abuse in the past five years	Diabetes	Major organ transplant recipient	Pulmonary fibrosis
Alzheimer's disease	Heart attack		Stroke – cerebrovascular accident
Any heart condition or heart trouble (excluding controlled hypertension)	Huntington's chorea		

1. Member Information (If applying for Member and/or Spousal coverage)

Name of Member (PLEASE PRINT)
 Last First Male Female

E-mail: Tel. Res: () Bus: ()

Member's Date of Birth (DD/MM/YY) Country of Birth
 Applicant is a/an: Engineer Student Technician/Technologist Limited Licensee
 Geoscientist Architect Permanent full-time employee of Association Member in Training
 Name of Prov./Terr. Assoc. Membership No.

2. Spouse Information (If applying for Spousal coverage)

Name of Spouse (PLEASE PRINT)
 Last First Male Female

Spouse's Date of Birth (DD/MM/YY) Country of Birth

E-mail: Tel. Bus: () Spouse's Occupation

3. How Much Insurance Are You Applying For?

Member Smoker Non-Smoker*

Please check one box.
 Essential 6 Condition Plan Indicate the amount you require in \$25,000 increments. **\$ _____,000**
 Enhanced 18 Condition Plan (10% discount applies to amounts of \$125,000 or more!) **Coverage Amount**

Spouse Smoker Non-Smoker*

Please check one box.
 Essential 6 Condition Plan Indicate the amount you require in \$25,000 increments. **\$ _____,000**
 Enhanced 18 Condition Plan (10% discount applies to amounts of \$125,000 or more!) **Coverage Amount**

Do you or spouse (if applicable) have any Critical Illness insurance in force or pending with another company?

Yes No – If yes, please state amount.

Member – Amount \$ Date issued or applied for

Spouse – Amount \$ Date issued or applied for

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

Member Name (Please Print) Last

First

Telephone

4. Method of Payment

MEMBER x = \$ x .9 (if applying for 5 or more units) = \$
Number of Units* Monthly Premium

SPOUSE x = \$ x .9 (if applying for 5 or more units) = \$
Number of Units* Monthly Premium

*1 unit of coverage is equal to \$25,000, a 10% discount applies to 5 units (5 x \$25,000 = \$125,000) or more. See the brochure for your monthly premium rate.

MONTHLY by Pre-Authorized Collection. Enclose a sample cheque marked "VOID."

OR

ANNUALLY x 12 = \$
Total Monthly Premium Amount Payable

My cheque is enclosed, made payable to Manulife Financial **OR**

Charge to my:   Card No. Expiry Date

I authorize Manulife Financial to make a monthly withdrawal from the account described on the accompanying specimen cheque for monthly insurance premiums due on or after the date of this authorization. The Pre-Authorized Collection Plan may be terminated either by the Company or by me through written notice. The Company also reserves the option to change the method of payment for another qualifying option after the occurrence of a deposit not honoured.

For your convenience, if you choose payment by Pre-Authorized Collection Plan or credit card, your future premium billings will automatically reflect the same payment method.

5. DECLARATION OF INSURABILITY

1. Member

Height m cm Weight kg lb
ft in lb
Any weight changes in the past 12 months? Yes No Indicate amount of change, if any kg lb
Loss Gain Reason:

2. Member

A. Name, Address and Telephone Number of your Regular Attending Physician:

B. Date last consulted:
Reason:
C. Diagnosis, treatment given or medication prescribed:

1. Spouse

Height m cm Weight kg lb
ft in lb
Any weight changes in the past 12 months? Yes No Indicate amount of change, if any kg lb
Loss Gain Reason:

2. Spouse

A. Name, Address and Telephone Number of your Regular Attending Physician:

B. Date last consulted:
Reason:
C. Diagnosis, treatment given or medication prescribed:

3. Have you ever had any insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?
If you answered "Yes" please provide details below.

MEMBER	SPOUSE
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Name	Details (If you need more space, please complete on a separate sheet of paper and sign and date it.)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Member Name (Please Print) Last

First

Telephone

5. DECLARATION OF INSURABILITY (continued)

4.

Have you ever:

- A. Consulted any physician, psychiatrist or other health care professional or been admitted to any hospital or similar institution other than for routine physicals or minor conditions (such as colds, flus, etc.)?
- B. Had any symptoms or adverse findings or were you advised to have further examinations, diagnostic tests, hospitalization or surgery not yet done?
- C. a) Have you ever had an abnormal electrocardiogram (ECG)?
b) In the past 5 years, have you had any abnormal examination, x-ray, blood test or other diagnostic test?
- D. In the past 5 years have you had any surgical operation, treatment, special diet, illness or injury?

MEMBER

SPOUSE

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

5.

- A. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?
- B. Are you receiving any treatment or taking any medication at the present time?

Yes No

Yes No

Yes No

Yes No

6.

Have you ever had or been treated for any disease or disorder of:

- A. The heart or blood vessels, such as heart murmur, heart palpitations, heart disease, heart attack, angina, chest pain, circulatory problems, phlebitis, stroke, transient ischemic attack (TIA), high blood pressure, high cholesterol, or any other disorder of the heart or circulatory system?
- B. The chest, lungs, nose, ear or throat, such as asthma, chronic bronchitis, emphysema, loss of speech, or any other chronic lung or respiratory disorder?
- C. The digestive system, including stomach, intestines, liver or pancreas, such as ulcer, colitis, bleeding or hepatitis, including carrier state?
- D. The kidneys, bladder, reproductive organs or prostate?
- E. The nervous system, such as dizziness, headaches, seizure, paralysis, epilepsy, Parkinson's, Alzheimer's, multiple sclerosis, motor neuron disease (ALS or Lou Gehrig's disease); or any other disease or disorder?
- F. The glandular system or blood, such as diabetes, anemia, leukemia or other disease or disorder of the blood or glandular system?
- G. The immune system, persistent lymph gland enlargement, unusual infections, any other immune system abnormality or had a positive test related to HIV or been diagnosed with AIDS?
- H. The breast, including lumps, cysts, unusual discharge, other physical changes, abnormal mammogram finding or biopsy?
- I. Cancer, tumour, polyp, mole, lump or other growth, any disorder of the skin or lymph glands, blood disorder or other form of malignant disease?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

7.

Have you ever had or been treated for an illness, disease, operation, injury or congenital defect not listed above or do you have any symptoms or complaints for which you have not yet consulted a physician?

Yes No

Yes No

8.

- A. Within the last two years, have you had your driver's licence suspended or had two or more moving violations?
- B. Have you used marijuana or taken drugs for other than medical purposes or been advised to reduce alcohol consumption or received treatment for drug or alcohol use?
- C. Have you used cigarettes in the past 12 months?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

If other forms of tobacco used, please give details. Member:

Spouse:

9.

Have any of your immediate family members (father, mother, brother(s) and sister(s) had heart disease, stroke, hypertension, aneurysm, cancer (specify type), diabetes, kidney disease, multiple sclerosis, Parkinson's disease, Alzheimer's disease, motor neuron disease or any other hereditary disorder?

If yes, please provide details.

Yes No

Yes No

Member Name (Please Print) Last

First

Telephone

5. DECLARATION OF INSURABILITY (continued)

IF ANY OF QUESTIONS 4 THROUGH 8 ARE ANSWERED "YES", GIVE DETAILS BELOW.

Question # & Part (e.g., 6, A)	Name of person to be insured	Include (when applicable) all information as to nature of illness, injury, or symptoms	Date Diagnosed	Result	Name and address of physician and hospital, if any

If you need more space, please complete, sign and date on a separate sheet of paper.

Member (IF "YES" ANSWERED TO QUESTION 9)

	Condition	Age of Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s)*					
Sister(s)*					

*If there are no siblings, indicate "none".

Spouse (IF "YES" ANSWERED TO QUESTION 9)

	Condition	Age of Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s)*					
Sister(s)*					

*If there are no siblings, indicate "none".

6. TERMS & CONDITIONS (PLEASE READ CAREFULLY BEFORE SIGNING)

I hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial).

I declare that the statements contained in this application are true and complete. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any policy issued hereunder.

I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I have read and understand that exclusions and limitations apply to the coverage applied for. Suicide is a risk not covered. Relative to the insurance applied for, I, the person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the Medical Information Bureau, the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health, to provide to Manulife Financial or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife Financial to consult its existing files for this purpose. I understand the insurer may request a medical examination, urinalysis or test which will be made at no expense to me and that the results of any positive infectious diseases will be reported to the appropriate health department if required by law.

I authorize Manulife Financial, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me their products or services. I understand that my consent to the use of such information to offer me products or services is optional and that if I wish to discontinue such use I may call or write to Manulife Financial at the telephone number or address shown on this document. "I" means "we" where more than one person is applying for insurance.

A photocopy or faxed copy of this authorization shall be as valid as the original.

I acknowledge receipt of the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.

I declare that I 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 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.

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.

Insurance will take effect on the date the properly completed application (including my properly completed Declaration of Insurability) and the first premium are received by Manulife Financial, subject to the approval of the insurer's underwriters. I understand that any health information must be accurate as at the date the application, including the Declaration of Insurability, is signed. If I am approved, I will receive a policy specifying the coverage provided and outlining the main policy provisions. I understand that if I am not insurable, a full refund of the premiums will be made.

I/we have read and understand the Terms and Conditions and accept them.

[Signature and Date boxes for Member's Signature]

Member's Signature

Date

[Signature and Date boxes for Spouse's Signature]

Spouse's Signature
(if applying for spousal coverage)

Date

[Large box for Representative's Name and Code No.]

Representative's Name

Stephen Wise

Code No.0239352/10470

[Signature box for Co-signature]

Co-signature
(for Pre-Authorized Collection, if required by bank)

[Date box for Co-signature]

Date

[Large empty box for additional information]