Manulife Financial

CANADIAN COUNCIL OF PROFESSIONAL ENGINEERS SPONSORED PLAN: APPLICATION FOR ASSOCIATION GROUP INSURANCE

1. Member Information

Name of Member (PLEASE PRINT)

Last ______ First ______ Male ☐ Female ☐

Unit/Apt. # ______ No./Street ______ City ______ Province ______ Postal Code ______

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

Member's Date of Birth (DD/MM/YY) ______ Birthplace: City ______ Country ______

Applicant is a/an: ☐ Engineer ☐ Student Engineer ☐ Technician/Technologist ☐ Limited Licensee
☐ Geoscientist ☐ Architect ☐ Permanent full-time employee of Association

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) ______ Birthplace: City ______ Country ______

Spouse's Occupation ______ Tel. Bus: ( ) ______

3. I am applying for

If currently insured under this Plan, your Certificate no. ______

☐ New coverage ☐ Additional coverage ☐ Replacement coverage for ______ units of Decreasing Term Life

Term Life Insurance *(Do not include units already in force.)*

	No. of Units		Monthly Premium Per Unit	MONTHLY PREMIUM
MEMBER Non-smoker ☐ Standard ☐	______	x	______	= $ ______
INSURANCE CONTINUATION BENEFIT *(No. of Insurance Continuation Benefit Units cannot exceed Term LIfe units applied for)*	______	x	______	= $ ______
SPOUSE Non-smoker ☐ Standard ☐	______	x	______	= $ ______
INSURANCE CONTINUATION BENEFIT *(Available only if Member is insured for Insurance Continuation Benefit)*	______	x	______	= $ ______

Major Accident Protection

MEMBER

Major Impairment	Up to $100,000	Up to $200,000	Up to $300,000	Up to $400,000	Up to $500,000	
Accidental Death	$10,000	$20,000	$30,000	$40,000	$50,000	
Monthly Premium	$1.50 ☐	$3.00 ☐	$4.50 ☐	$6.00 ☐	$7.50 ☐	= $ ______

SPOUSE

Major Impairment	Up to $100,000	Up to $200,000	Up to $300,000	Up to $400,000	Up to $500,000	
Accidental Death	$10,000	$20,000	$30,000	$40,000	$50,000	
Monthly Premium	$1.50 ☐	$3.00 ☐	$4.50 ☐	$6.00 ☐	$7.50 ☐	= $ ______

Child Life and Accident Insurance (The monthly premium covers all of your eligible children.)

Major Impairment	Up to $50,000	Up to $100,000	Up to $150,000	Up to $200,000	Up to $250,000	
Term Life	$5,000	$10,000	$15,000	$20,000	$25,000	
Monthly Premium	$1.17 ☐	$2.33 ☐	$3.50 ☐	$4.67 ☐	$5.83 ☐	= $ ______

TOTAL MONTHLY PREMIUM = $

4. Medical Questionnaire

(PLEASE PRINT)

Member: Last name ____ First Name ____ Telephone Number: ____

Spouse: Last name ____ First Name ____
(if applying for spousal coverage)

Member's Physician – Name: ____ Tel. # ( ) ____ Date last seen (DD/MM/YY) ____

Reason ____ Result ____

Spouse's Physician – Name: ____ Tel. # ( ) ____ Date last seen (DD/MM/YY) ____

Reason ____ Result ____

Member's Height ____ Weight ____ Spouse's Height ____ Weight ____

Has any individual proposed for coverage (member, spouse, children):

Question	Member YES	Member NO	Spouse YES	Spouse NO	Child(ren) YES	Child(ren) NO
1. Ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumours, lung or liver disorders, hepatitis (including carrier state), unusual infection or immune system abnormality, kidney disorders, urinary abnormality, drug or alcohol consumption, or other illness or injury?	❑	❑	❑	❑	❑	❑
2. Ever had back, neck or knee trouble, had any x-rays of spine or joints, or received any injuries for which he/she was hospitalized or was unable to work?	❑	❑	❑	❑	❑	❑
3. Ever had any positive test or exposure to AIDS/HIV virus or, during the past two years, had any medical or surgical advice, been hospitalized, treated or given medication for any ailment other than routine checkups or minor ailments (colds, flus, etc.)?	❑	❑	❑	❑	❑	❑
4. Ever applied for any insurance that was declined, modified or rated?	❑	❑	❑	❑	❑	❑
5. Engaged in, or intend to engage in, any hazardous sport or activity (flying, racing, scuba or sky diving, climbing, etc.)?	❑	❑	❑	❑	❑	❑
6. Ever had his or her driver's licence suspended? If yes, driver's licence no. ____	❑	❑	❑	❑	❑	❑
7. Smoked cigarettes in the last 12 months? (If other forms of tobacco used, give details below.)	❑	❑	❑	❑	❑	❑

If "yes" answered to any of questions 1 to 4 above, give details below. For 5 and 7, use separate page.

Ques. #	Name	Nature of Disorder	Duration & Date	Result	Attending Physician or Hospital

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

Note to Québec residents: If you choose, you may mail the Medical Questionnaire (page 2) separately to Manulife Financial (see address on bottom of page 3).

5. Method of Payment

ANNUAL ☐ $ ____________ x ____________ + ____________† = $ ____________

Total Monthly Premium | No. of Months to April 1st (excluding present month) | Provincial Sales Tax if applicable | AMOUNT PAYABLE TO NEXT APRIL 1ST

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

☐ ***Charge to my:*** ☐ MasterCard ☐ VISA Card No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date ☐☐☐☐

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

$ ____________ + $2.00 + ____________† = $ ____________

Total Monthly Premium | Service Charge | Provincial Sales Tax if applicable | MONTHLY AMOUNT PAYABLE

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.

† Residents of Ontario add 8% Provincial Sales Tax. Residents of Québec add 9% Provincial Sales Tax.

6. Beneficiary Information

Beneficiary on Member's Coverage

Last name First name

Relationship

Beneficiary on Spousal Coverage

Last name First name

Relationship

In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary ❑

7. Terms and Conditions *(Please read carefully before signing)*

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

I/we declare that the statements contained in this application are true and complete. I/we understand that this application together with any other forms signed by me/us in connection with this application, form the basis for any certificate issued hereunder.
The person(s) to be insured understand(s) 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 the exclusions and limitations that apply to the coverage applied for. Relative to the insurance applied for, I/we, the person(s) to be insured, or parent/guardian if the person to be insured is a minor, 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/us or my/our health or the health of any member of my/our family to be insured under this plan to provide to 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 the information in this application and its existing files to offer me/us their products or services. I/we understand that my/our consent to the use of such information to offer me/us products or services is optional and that if I/we wish to discontinue such use I/we may write to Manulife Financial at the address shown on this document.
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 (the member) hereby designate the individual(s) named as beneficiary to receive the proceeds payable upon my or my spouse's death.
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.
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/our properly completed Health Declaration) and the first premium are received by Manulife Financial, subject to the approval of the Company's underwriters. I understand that any health information must be accurate as at the date the application is signed. If you are approved, you will receive a certificate specifying the coverage provided and outlining the main policy provisions. If you are not insurable, a full refund of the premiums will be made.

Member's Signature Date

Spouse's Signature (if applying for spousal coverage) Date

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

Representative Name Stephen Wise - London Code No. 0239352/10470