

**Send all completed Applications and Mail for Personal Accident Disability Insurance to:**

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Manulife Financial  
Personal Accident  
2 Queen St. E.  
Toronto, ON  
M5C 3G7 (courier address)

**Note:** If you are contracted through a Managing General Agency or National Account Firm please forward your application to their office.

**How to inquire on the status of a pending Personal Accident Disability Insurance application:**

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- Call toll free at 1 (888) 477-5450 or e-mail PACR\_Admin@manulife.com

**Premium Collection:**

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- The initial premium must be collected and submitted together with the application for insurance. **Coverage is not available on a COD basis.** You will need to collect the first **two monthly premiums** or one full annual premium. Cheques should be dated the same date the application is signed. Post-dated cheques are not accepted.
- If the Credit Card payment option has been selected, we will process a billing for the first 2 monthly premiums or full annual premium upon receipt of the application.
- Regular monthly pre-authorized debits and/or Credit Card billing will be processed in the 3rd month following the policy effective date on the billing date selected.

**Example:** Policy Effective Date = April 1st and Billing Day = 15th

Coverage Period	Premium Billing
April 1st to May 1st	Initial deposit – 1st monthly premium credited
May 1st to June 1st	Initial deposit – 2nd monthly premium credited
June 1st to July 1st	1st premium withdrawal would be processed on the 15th of June

**Effective Date:**

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- The effective date of the policy contract will be the date the application is signed. Any applications dated the 29, 30 or 31st will be effective the 1st day of the next month.
- If Sickness Disability coverage has been applied for, the effective date for this coverage will be as follows:
  - if approved within 30 days – date the application was signed (same as Accident Coverage)
  - if approved after 30 days – the next monthly anniversary day following date of approval

**Policy Mailing:**

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- We will mail the policy document to you for delivery or directly to your client. Policies that are not issued as applied for, issued with exclusions or Head Office Amendments will be sent to the Advisor for delivery.

**Returned Cheques – Initial Premium:**

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If the initial premium is returned by the bank:

- The policy will be processed as a NOT TAKEN, and commissions will be reversed.
- A letter is sent to the client (copy to agent) requesting a replacement cheque within 20 days otherwise a new application must be submitted.

Mail to: Personal Accident  
2 Queen St. E., P.O. Box 4213, Stn A  
Toronto, Ontario M5W 5M3

H.O. use only
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Please ensure all changes/corrections are initiated by the primary insured/owner. Do not use white-out on this application.

**PLEASE PRINT**

Addition to Policy Number **S** \_\_\_\_\_

**PART 1**

**A. Primary Insured Information**

Please contact me at:  Home  Work  Email \_\_\_\_\_

1. First Name	Middle Initial	Last Name	Maiden Name	H.O. use only
2. Number & Street		City	Province	Postal Code
3. Residence Telephone Number ( )		4. Business Telephone Number ( )		5. Date of Birth (dd/mm/yy)
6. Age		7. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		8. Social Insurance Number
9. Policy Language English <input type="checkbox"/> French <input type="checkbox"/>		10. Place of Birth		
11. Primary Occupation		12. Length of Time	13. Duties (detailed description)	
14. Name & Address of Company/Employer			15. Secondary Occupation	16. Hours per week
17. Are you a permanent resident of Canada? Yes <input type="checkbox"/> No <input type="checkbox"/> (Answer must be 'yes' to be eligible for insurance)		18. Will this insurance replace any existing income replacement insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> (Complete only if residing in Quebec. If "YES", complete required form)		
19. Beneficiary <b>Note:</b> In the Province of Quebec, unless stated to be revocable, a spousal beneficiary is irrevocable. If more than one beneficiary, benefits will be paid in equal shares, unless otherwise stated.			20. Relationship to Primary Insured	H.O. use only
21. Owner (Complete only if Primary Insured is a minor; otherwise the Owner is the Primary Insured.)		22. Owner's Date of Birth (dd/mm/yy)	23. Relationship to Primary Insured	H.O. use only

**B. Accident Disability Plan**

	Benefit Amount	Annual Premium
1. 24 Hour Compensation (2 Year Benefit)	<input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 120 day elimination period	\$

**C. Accident & Sickness Disability Riders**

Coverage Information – Please (✓)

	Coverage Information	Benefit Amount	Annual Premium
2. 24 Hour Compensation (E) (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 0 <input type="checkbox"/> 30 or <input type="checkbox"/> 120 Days	\$	\$
3. Non-Occupational Loss of Income (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 0 Days or <input type="checkbox"/> 120 Days	\$	\$
4. Sickness Disability (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 30 Days or <input type="checkbox"/> 120 Days or <input type="checkbox"/> 15 Day Retro	\$	\$
5. 24 Hour Accident Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$
6. Non-Occupational Accident Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$
7. Sickness Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$

**D. Additional Riders**

Coverage Information & Benefit Amount – Please (✓)

	Coverage Information & Benefit Amount	Annual Premium
1. Accidental Death & Dismemberment	Accident Death Benefit Amount: <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$300,000	\$
2. Accident Excess Medical	Accident Paramedical Services Benefit Amount: <input type="checkbox"/> Plan A – \$400 <input type="checkbox"/> Plan B – \$600 <input type="checkbox"/> Plan C – \$800	\$
3. Return of Premium	Exclude On:	\$
4. Return of Premium on Death	Exclude On:	\$
5.		\$
<b>Total Annual Premium</b> (Monthly Premium = Annual Premium ÷ 12)		\$

**E. Eligibility – For all Plans and Riders**

Answers to Questions 1, 2a), 2b) & 3 must be “No” to be eligible for any coverage.

1. Are you currently totally or partially disabled or receiving disability benefits or a disability pension?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. a) Do you have any physical impairments?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Do you have a physical impairment that limits your ability to perform your normal occupation(s) and/or engage in all of the functions of your normal daily routine? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Are you currently receiving social assistance (welfare) benefits?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**F. Employment Eligibility**

Complete for Accident and Sickness disability benefit amounts exceeding \$1,000 per month AND for ANY amount of 24 Hour Accident Disability Extension, Non-Occupational Accident Disability Extension and Sickness Disability Extension.

1. Do you currently work 30 or more hours per week? (Answer must be “Yes” to be eligible).....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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**G. Financial Information and Existing Insurance**

Complete for Accident and Sickness disability benefit amounts exceeding \$2,000 per month for ANY coverage under Part 1, Sections B. & C.

1. Gross Annual **Personal** Earned Income (subtract E.I./U.I.) \_\_\_\_\_ x 75% = \_\_\_\_\_ ÷ 12 = \_\_\_\_\_ /Eligible Monthly Income.  
(Employees: T1, lines 101 + 104. Self-Employed: T1, lines 135 to 143)

2. If self-employed .....Gross Annual **Business** Income \_\_\_\_\_  
 – Purchases; sub-contracts; wages & salaries; investment; interest; rental & government plan incomes \_\_\_\_\_  
 (Business Income: T2124, lines 8299 less lines 8300 to 8515 and 9060) = Eligible Business Income \_\_\_\_\_

a) No full-time employees:  
 Eligible Business Income \_\_\_\_\_ x % of ownership \_\_\_\_\_  
 = \_\_\_\_\_ x 75% = \_\_\_\_\_ ÷ 12 = \_\_\_\_\_ / Eligible Monthly Income.

b) With full-time employees:  
 Eligible Business Income \_\_\_\_\_ x % of ownership \_\_\_\_\_  
 = \_\_\_\_\_ x 1% = \_\_\_\_\_ / Eligible Monthly Income.

3. Are you covered by the Worker’s Compensation Board in your province of residence? ..... Yes  No   
 If “Yes”, provide coverage amount below. This amount will be considered when calculating the monthly benefit you qualify for.

4. Do you currently have Disability Insurance? ..... Yes  No   
 If “Yes”, provide details below. This amount will be considered when calculating the monthly benefit you qualify for.

Question No.	Details

**PART 2**

Primary Insured \_\_\_\_\_

**H. Medical Questionnaire** for Sickness Disability and Sickness Disability Extension.

Date of Birth \_\_\_\_\_

Before applying, it is important to understand that this coverage is not available to you if you have any of the following conditions:

Active hepatitis	AIDS or AIDS-related disease	Alcohol abuse in the past 5 years
Alzheimer's disease	Any heart condition or heart trouble (excluding controlled hypertension)	Cancer – except basal cell skin cancer
Coronary bypass surgery	Diabetes	Heart attack
Huntington's Chorea	Lou Gehrig's disease – amyotrophic lateral sclerosis (ALS)	Lupus
Multiple Sclerosis	Stroke – cerebrovascular accident	Transient Ischemic Attack

Your Physician's Name: \_\_\_\_\_ Physician's Address: \_\_\_\_\_

Date last seen: \_\_\_\_\_ Reason last seen: \_\_\_\_\_

Tests, treatment, medication prescribed (if none, state "None"): \_\_\_\_\_

Results and current status: \_\_\_\_\_

Your height: \_\_\_\_\_ ft & in/cm Your current weight: \_\_\_\_\_ lb/kg Has your weight changed in the past year?  Yes  No

If yes: Gained \_\_\_\_\_ lb/kg Lost \_\_\_\_\_ lb/kg Reason for change: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS AND PROVIDE FULL DETAILS BELOW OR ATTACH A SEPARATE SHEET, SIGNED AND DATED. HAVE YOU:**

- Ever applied for any insurance that was declined, modified or rated? ..... Yes  No   
If yes, give date, name of company and reason: \_\_\_\_\_
  - 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? ..... Yes  No   
If yes, give details including drug or alcohol type(s) and date(s) last used: \_\_\_\_\_
  - Female applicants only: Are you currently pregnant? ..... Yes  No   
If yes, give due date: \_\_\_\_\_  
Have you ever had a miscarriage, preeclampsia, caesarean section or other complication of pregnancy? ..... Yes  No   
If yes, give date and details: \_\_\_\_\_
  - 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), positive test, treatment for or exposure to HIV virus, 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? ..... Yes  No
  - 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? ..... Yes  No
  - 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 counseling for any disorder other than minor ailments (colds, flu etc), been advised to undergo further investigation, see another doctor or have surgery? ..... Yes  No
- If you answered "yes" to Questions 4 through 6 above, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question #	Nature of Disorder	Date and Duration	Treatment and Current Status	Attending Physician or Hospital

- Have any of your parents, brothers or sisters had heart disease, diabetes, cancer, stroke, high blood pressure, kidney disease, hepatitis, Huntington's Chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease or genetic disorder? ..... Yes  No   
If yes complete the following:

Family Member	Condition (if cancer, specify type)	Age of Onset	Age at Death and Cause


**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 test will be reported to the appropriate health department if required by law.**

**I understand that the coverage I am applying for may be rescinded due to non-disclosure of medical history.** \_\_\_\_\_ (client initials)

**I. Payment Authorization Plan** Complete method of payment below.

**Monthly:**  PAC \*Attach blank cheque marked "VOID"  Visa  Mastercard  
 Debits/Billing shall be drawn on the  1st  15th day of each month  Other \_\_\_\_\_ (1st to 28th only)  
**Annual:**  Cheque (payable to "Manulife Financial")  Visa  Mastercard  
 Card Number:                       
 Expiry Date:

I authorize Manulife Financial to withdraw premiums due from my bank or to charge my credit card from the account described above.  
 This Payment Authorization Chequing (PAC) Plan may be terminated at any time upon 10 days written notice by the Company, Payor, or the owner. If a pre-authorized debit is returned or a credit card billing is rejected, the Company is authorized to redeposit the debit or add the appropriate amount to the next debit. The Company will, to the best of its ability, advise the owner or the payor in writing of the revised amount being debited or charged.



\_\_\_\_\_  
 Payor(s) Name (Please Print) Authorized Payor Signature Date H.O. use only

**J. K. & L. Declaration, Acknowledgement and Authorization**

**J. Declaration**

**It is agreed that:**

1. All statements and answers made in this application and in any document completed in connection with this application are complete and true, and such statements and answers will form the basis of the policy.
2. No representative of Manulife Financial is authorized to modify this application or the policy.
3. Acceptance of any policy issued which is based on this application constitutes approval of the terms, conditions, limitations, exclusions, and other provisions of the policy.
4. The policy will take effect on delivery to the Primary Insured on condition that:
  - a) The initial premium has been paid,
  - b) There has been no change in insurability of the proposed Insured Person(s) since completion of the application, and
  - c) All the statements and answers made at the time of the application are still complete and true as of the time of delivery.

**K. Acknowledgement**

It is acknowledged that notice has been received of disclosure concerning a consumer report and the Medical Information Bureau. Consent is given to obtain such report(s). The agent has signed a contract with Manulife Financial, as a representative entitled to receive commissions and may receive other benefits for placing this insurance. Commissions may be payable to more than one agent, if so they are split as indicated in Section M. Agent Report. For policies of this type the Insurer anticipates that 45% of the premium will be required for claims. This is not a contractual obligation.

**L. Authorization**

I understand that The Manufacturers Life Insurance Company ("Manulife Financial") or its reinsurer(s) will require information for the purpose of approving the application, administering the contract, and considering any claim on insurance arising from this application. I authorize any physician, medical practitioner, hospital, clinic or any other medical or medically-related facility, insurance company, the Medical Information Bureau, other organization or person that has any records or knowledge of me to give The Manufacturers Life Insurance Company (Manulife Financial) or its reinsurers any such information. I consent to Manulife Financial acquiring information about me and my health. I consent to any examination, x-rays, electrocardiograms, blood and urine tests as Manulife Financial may require to underwrite my application for insurance. The tests may include but are not limited to tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders, infection by the Acquired Immune Deficiency Syndrome (AIDS) virus, and the presence of medications, drugs, nicotine or their metabolites. I further consent to Manulife Financial releasing the results of these tests to its reinsurers if involved in the underwriting, to my attending physician, and to the Medical Information Bureau, or the appropriate health department if required by law. I understand why I have been asked to disclose this information, including my individually identifying information, and am aware of the risks and benefits of consenting or refusing to consent to the disclosure of the information listed above. I understand that I may revoke this consent at any time. I also understand that if I revoke my consent, the recipient of this information will be unable to fulfill the purpose(s) stated above. I agree that a copy of this authorization shall be as valid as the original.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_



\_\_\_\_\_  
 Signature of proposed Primary Insured (or Owner if proposed Primary Insured is a minor) Signature of Agent

**M. Agent Report**

Premium Amount Collected or to be Billed: \$ \_\_\_\_\_

Mail Policy to:  Primary insured  Agent, Mailing Address \_\_\_\_\_  
 Agent Name \_\_\_\_\_ Agent Code \_\_\_\_\_ Split cases \_\_\_\_\_ %  
 Second Agent Name \_\_\_\_\_ Agent Code \_\_\_\_\_ Split cases \_\_\_\_\_ %  
 Distribution Channel:  Managing General Agency Code \_\_\_\_\_  National Accounts Code \_\_\_\_\_  
 Medical Requirements \_\_\_\_\_ Date Ordered \_\_\_\_\_ Reference # \_\_\_\_\_  
 Comments \_\_\_\_\_

**N. For Head Office Use Only**

- This Policy is issued with a Head Office Amendment – see page P900 of the policy document for full details  
 This Policy is issued with an Amendment – see page P950 of the policy document for full details

## Important Notice on Exchange of Information

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All information requested will be for insurance purposes only and will be treated as confidential. The Insurer or its reinsurers may, however make a brief report on it to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, the bureau will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, the bureau will arrange for disclosure to you of any information it may have in your file on you. If you question the accuracy of the bureau's file, you may contact the bureau and seek a correction. The address of the bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

## Important Notice on Privacy and Confidentiality

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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 the office of the administrator. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 2 Queen St. E., P.O. Box 4213 Stn A, Toronto, Ontario M5W 5M3.

## Temporary Insurance Agreement

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Manulife Financial, (the Company) agrees to provide Temporary Insurance coverage as applied for, provided the initial premium or credit card billing has been honoured by the financial institution and the questions in Section (E) are answered "NO", (reference # 1, 2a), 2b), or 3), subject to the following:

1. The terms, conditions, limitations, and exclusions, and other provisions of the policy applied for, will govern.
2. This agreement **DOES NOT** cover Sickness Disability or Sickness Disability Extension.
3. Temporary Insurance coverage ceases on the earliest of: a) the date the policy applied for becomes effective; or  
b) sixty (60) days from the date of the Payment Acknowledgement noted below; or  
c) the date the Company sends notice to the proposed Primary Insured declining the application.

**No representative of Manulife Financial is authorized to modify this agreement.**

## Payment Acknowledgement

The Company acknowledges payment of or authorization to bill the initial premium of \$ \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_