Canadian Professional Sales Association
Application for Long Term Disability Insurance

Manulife Financial
For your future™

Member Information *(Please print)*

Last Name | First | ☐ Non-Smoker* ☐ Smoker ☐ Male ☐ Female

Address | City | Province | Postal Code

Date of Birth DD/MM/YYYY | Country of Birth | Membership No.

E-mail | Tel. (Home) | (Bus.)

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* Non-smoker rates apply to people who have not used any tobacco products or tobacco cessation products for a period of at least 12 consecutive months immediately preceding the date of application.

Long Term Disability *(Do not include any coverage currently in force.)*

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

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

A. Please indicate the monthly benefit amount you are applying for in $100 increments (from a minimum of $500 to a maximum of $7,500) $

B. Check if you would like to add Cost of Living Rider ☐ Yes ☐ No

C. Are you eligible for Employment Insurance? ☐ Yes ☐ No

D. Choose a Waiting Period before benefits begin: ☐ 60 days ☐ 119 days*

*If you are covered by Employment Insurance select a Waiting Period of 119 days.

Financial/Employment Information

A. Employment Status: ☐ Employee ☐ Self-Employed

If self-employed, what is the organizational structure of your business? ☐ Sole Proprietor ☐ Partnership ☐ Corporation

If owner of a partnership or corporation, give percentage ownership: _____ %. Start-up date: _____ DD/MM/YYYY

B. Occupational Duties (Give description of duties and percentage of time spent performing each): _____

C. Will any income be continued during disability by your employer or as a result of a partnership agreement? ☐ Yes ☐ No

If yes, what percentage? _____% For how many months? _____

D. Have you declared or are you contemplating personal or business bankruptcy? ☐ Yes ☐ No

If yes, provide details including date of discharge:

E. Annual Net Earned Income, after expenses but before taxes $ _____

Proof of Income:
If applying for more than $3,500/month total coverage (applied for and existing with all companies), please submit pages 1, 2 and 3 of your last 2 years' tax returns.
If incorporated, please also submit your last corporate financial statement.

F. Do you have any pending or existing disability coverage with Manulife Financial or any other company? ☐ Yes ☐ No
If yes, complete the following:

Company Name	Coverage Amount	Waiting Period	Benefit Period	Taxable?	Will this coverage be replaced?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new certificate.

Method of Payment

☐ **ANNUAL**

☐ **Charge to my** ☐ MasterCard ☐ Visa

Card No. | | | | | | | | | | | | | | | |

Expiry Date M M Y Y

Name of Cardholder
(if other than Member) _____

☐ **By cheque,** payable to Manulife Financial, in the amount below:

$	x		+	$	=	$
Total Monthly Premium[1]		Number of months to March 1st (excluding current month)		Provincial Sales Tax (if applicable*)		AMOUNT PAYABLE

☐ **MONTHLY**[1]

☐ **Charge to my** ☐ MasterCard ☐ Visa

Card No. | | | | | | | | | | | | | | | |

Expiry Date M M Y Y

Name of Cardholder
(if other than Member) _____

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

1 Call Manulife Financial for monthly premium.

* Taxes:
Residents of Ontario add 8% PST
Residents of Québec add 9% TVQ
Residents of Manitoba add 8% RST

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 financial institution is required for pre-authorized payments from accounts with no chequing privileges, I have made prior arrangements to allow for pre-authorized payments from my account. Enclosed is a withdrawal slip that has been stamped by my financial institution allowing withdrawals to be made from my non-chequing account.

PAYMENT AUTHORIZATION

For Credit Card payment options

I hereby authorize Manulife Financial to make a withdrawal from my 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 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.

Name of Cardholder _____ Signature of Cardholder _____

Second Signature If Joint Account _____ Dated _____ DD/MM/YYYY

For Pre-Authorized Debit (PAD) payment options

I authorize Manulife Financial to withdraw monthly premiums from my bank account for insurance premiums due on or after the date I sign this authorization. I 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 account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. **I waive the right to receive further notice of the amount and date of each automatic withdrawal.** If my 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 for an alternate method of payment if my payment is not honoured. All one-time or automatic withdrawals from my bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I and/or Manulife Financial can end this agreement at any time by giving 10 days' written notice. I 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 1 800 482-0758, 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.

To authorize all Pre-Authorized Debit (PAD) payments, please sign below.

Name of Account Holder _____ Signature of Account Holder _____

Second Signature If Joint Account _____ Dated _____ DD/MM/YYYY

Account Holder Address (if different from Applicant) _____

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

Underwriting Questionnaire

Member's Full Name	Home Telephone
Member's Physician (Name)	Physician's Telephone
Physician's Address	
Date Last Seen DD/MM/YYYY	Reason Last Seen
Tests, Treatment, Medication prescribed (if none, state "None")	
Results and Current Status	

Your Height ☐ ft/in ☐ cm Your Weight ☐ lbs ☐ kg

Has your weight changed in the past year? ☐ Yes ☐ No ☐ Gained ☐ Lost ☐ lbs ☐ kg

Have you:

	YES	NO
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:	☐	☐
2. Within the past 5 years, had your driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including 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 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 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 drug or alcohol type(s) and date(s) last used:	☐	☐

Continued on page 4.

Underwriting Questionnaire *(Continued from page 3)*

Have you:

	YES	NO
6. 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?	☐	☐
7. 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?	☐	☐
8. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?	☐	☐
9. 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 6, 7, 8 or 9, 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

	YES	NO
10. 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? If yes, complete the following:	☐	☐

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

	YES	NO
11. 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:	☐	☐

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. 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.

QUÉBEC RESIDENTS ONLY:

After completion you **may** send pages 3 and 4 to Manulife Financial, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8

Terms & Conditions

NOTICE ON EXCHANGE OF INFORMATION: 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, your spouse or your children being insured under this plan. If you question the accuracy of the Bureau's file, you may contact the Bureau to seek a correction. The address of the Bureau's information office is: 330 University Avenue, Toronto, Ontario M5G 1R7. Telephone (416) 597-0590.

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, P.O. Box 4213, Stn. A, Toronto, Ontario M5W 5M3.

DECLARATION: I hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I 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 in connection with this application, form the basis for any certificate issued hereunder. I have read and understand that there are exclusions and limitations on the coverage applied for. I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I understand that insurance will take effect on the date my 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 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, the undersigned 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 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, 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 authorize Manulife Financial to consult its existing files for this purpose. I authorize Manulife Financial, its subsidiaries, affiliates and agents to use this information to offer me their products and services. I understand that my consent to the use of this 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. A photocopy or faxed copy of this authorization shall be as valid as the original.

I have read and confirm my agreement with 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 seven 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.

FOR QUEBEC RESIDENTS ONLY

☐ 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)	Date DD/MM/YYYY
Agent of Record/Broker (if applicable)	Agent ID	Date DD/MM/YYYY

QUESTIONS?

Call Manulife Financial, toll-free: **1-800-482-0758** or e-mail: **am_service@manulife.com**

PLEASE SEND YOUR COMPLETED APPLICATION, ALONG WITH PAYMENT, TO:

Manulife Financial, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8