

IMPORTANT NOTE: 1. To qualify for a change to non-smoker rates, the Insured must meet Manulife's non-smoker definition and health standards 2. Complete all answers in full for the insured person(s) applying for a change to non-smoker rates		
Applicant's Name	Certificate/Policy No.	Date of Birth (dd/mm/yyyy)
Spouse's Name	Certificate/Policy No.	Date of Birth (dd/mm/yyyy)
Address		Telephone Number

	Applicant Information	Spouse Information
1. Have you ever used tobacco, tobacco cessation products (e.g. Nicorette gum, Nicotine patch) or marijuana? If "yes", indicate: _____ Product type(s): _____ Date(s) last used: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Since the date of your last medical declaration to us: (a) Have you had or been treated for a mental or nervous disorder (depression, anxiety, etc.) heart or circulatory disorders, chest pains, high blood pressure, elevated cholesterol, diabetes, cancer, tumor, unusual infection or immune system abnormality, asthma, chronic cough or lung disorder, urine abnormality, or other illness or injury, other than minor ailments such as colds or flu, etc.? (b) Have you consulted a physician other than for routine check-ups, received any medical advice or treatment, undergone any tests or taken medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you awaiting any pending tests, test results or investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If any "Yes" answers to questions 2 or 3 above, give details below:

Name	Nature or Disorder, Test or Investigation	Date	Duration (if applicable)	Result and Current Status	Name of Attending Physician or Medical Facility

4. a) Applicant's Current weight: _____ lbs. kg. Height: _____ feet/inches centimetres
 b) Spouse's Current weight: _____ lbs. kg. Height: _____ feet/inches centimetres

The statements contained herein are true and complete, and together with other forms signed by me/us in connection with this application, form the basis for any certificate issued hereunder. I/we agree that any material misrepresentation, including misstatement of smoking status, shall render the policy change voidable at the instance of the insurer.

Relative to this application, I/we hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me/us or of any member of my/our family insured under this plan, or of our health, to give to the Manufacturers Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

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 and seek a correction. The address of the Bureau's Information Office is: 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

Applicant Signature

Date Signed (dd/mm/yy)

Spouse Signature (if applying for a spousal change)

Date Signed (dd/mm/yy)