# THE MANUFACTURERS LIFE INSURANCE COMPANY

## CPA Select* Catastrophic Health Insurance

## APPLICATION

CPA CHARTERED PROFESSIONAL ACCOUNTANTS ONTARIO

- **All applicants must complete all sections**
- **All applicants must complete and sign the Applicant's Declaration on Page 5**



## PART A • GENERAL INFORMATION

Member's Last Name _____ First Name _____ Initial _____

Apt. Number _____ Street Number and Name _____ Home Telephone (  ) _____

City or Town _____ Province _____ Postal Code _____ Occupation _____

Membership No. _____

Member's Office Telephone (  ) _____ Spouse's Office Telephone (  ) _____

Member's Fax (  ) _____ Spouse's Fax (  ) _____

Member's E-mail _____ Spouse's E-mail _____

**Does each applicant have provincial/territorial health care coverage?**** ☐ Yes ☐ No

**All applicants must have coverage under a provincial/territorial health care insurance plan in order to be eligible for this insurance product.
If anyone on the application does not meet this requirement, please contact our Customer Service for more information.

If additional information is required during regular business hours, how may we contact you? ☐ Home Tel. ☐ Office Tel. ☐ E-mail

Are you now covered or did you recently have employer group health insurance coverage? ☐ Yes ☐ No

If "Yes", please indicate:

Group Plan Number _____ ID Number _____ Insurance Company _____ Date benefits ended? DD/MM/YYYY

Group Plan Number _____ ID Number _____ Insurance Company _____ Date benefits ended? DD/MM/YYYY

Is this application intended to replace your current coverage? ☐ Yes ☐ No

Do you have any existing insurance coverage with Manulife through the CPA Select Insurance Plans ☐ Yes ☐ No

If "Yes", provide Certificate No. _____

## PART B • INDIVIDUALS TO BE COVERED

| FIRST NAME | LAST NAME | CODE 00 | SEX | BIRTH DATE DD MM YYYY | AGE | SMOKER? NO. OF CIGARETTES DAILY | HEIGHT inch / cm | WEIGHT lbs / kg | WEIGHT CHANGE IN LAST YEAR GAIN LOSS | REASON FOR WEIGHT CHANGE |
|---|---|---|---|---|---|---|---|---|---|---|
| MEMBER | | 01 | | I I | | | | | I | |
| SPOUSE | | 02 | | I I | | | | | I | |
| DEPENDANT | | 02 | | I I | | | | | I | |
| DEPENDANT | | 02 | | I I | | | | | I | |
| DEPENDANT | | 02 | | I I | | | | | I | |
| DEPENDANT | | | | I I | | | | | I | |

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If you require more space to complete any part of this application, please attach a separate sheet.

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# PART C • PAYMENT OPTIONS

### Initial Payment

I/We hereby authorize Manulife to debit the initial two (2) months' premium, $ _____ , from my/our:

Option #1 ☐ Financial Services Account (Pre-Authorized Debit)
*Important: For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part D.*

Option #2 ☐ Credit Card Account
*Please complete Part D.*

**Subsequent Payments** will be made by:

Option #1 ☐ Pre-Authorized Debit (PAD) from my Financial Services Account
PAD Billing Frequency: Monthly
*Important: For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part D.*

Option #2 ☐ Credit Card Account
Credit Card Billing Frequency: ☐ Monthly ☐ Annually
*Please complete Part D.*

Option #3 ☐ Direct Billing
Direct Billing Frequency: Annually (4% discount)

**Note:** Billing frequency discounts are not available for Credit Card payment options.

# PART D • PAYMENT INFORMATION and AUTHORIZATION

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

**For Credit Card payment options**

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Account Number _____-_____-_____-_____ Expiry Date _____ /_____

Name of Cardholder _____ Signature of Cardholder _____

Based on your or your family's medical history, coverage may be declined or modified to exclude certain conditions or be given a higher premium. Coverage will commence no earlier than the first of the month following final approval of this application.

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# PART D • PAYMENT INFORMATION and AUTHORIZATION (Cont.)

### Payment Authorization

**For Pre-Authorized Debit (PAD) payment options**

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract and as required to administer my/our policy. **I/We waive the right to receive further notice of the amount and date of each automatic withdrawal from my/our account.** If the bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by Payments Canada. I/We or Manulife may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife 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 1 866-219-4245, CPAselectplans.com or write to us at Manulife, 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, contact your financial institution or visit www.payments.ca.

Name of Account Holder _____ Signature of Account Holder _____

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

Account Holder Address (If different from Applicant) _____

**For Credit Card payment options**

I/We hereby authorize Manulife to make a withdrawal from my/our 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 or by me/us through written notice.

Manulife 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. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

Second signature if joint account _____ Dated _____ DD / MM / YYYY

# SECTION A • TREATING QUALIFIED HEALTH CARE PRACTITIONER

Name and address of present Primary Health Care Provider/Physician (who holds the majority of your medical records) and any other Qualified Health Care Practitioners consulted (if none, print "none"):

| Primary Health Care Provider | For Member | For Spouse | For Dependant(s) |
|---|---|---|---|
| Name of Primary Health Care Provider | | | |
| Address of Primary Health Care Provider | | | |
| Date of Last Consultation | | | |
| Reason for Last Consultation | | | |
| Diagnosis Made | | | |
| Treatment Given | | | |

Name and telephone number of any other Qualified Health Care Practitioner consulted _____

_____

_____

Date and reason for consultation _____

_____

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**IMPORTANT: Any reference to testing, tests, test results, or investigations in this section excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or**

# SECTION B • MEDICAL QUESTIONNAIRE

Additional medical information may be required to underwrite your application.

1. Have you, your spouse or any listed dependant ever consulted a Physician or Qualified Health Care Practitioner about, been treated for, or had any known indication of:
(✓ "Yes" or "No" to all questions)

a) High blood pressure, high cholesterol, any circulatory or blood disorder ☐ Yes ☐ No

b) Heart or blood vessel disorder, heart murmur, chest pain, angina, stroke, or transient ischemic attack (TIA) ☐ Yes ☐ No

c) Back, neck, disc, hip, knee or joint pain or disorder, fibromyalgia, osteoporosis, osteopenia, chronic pain, paralysis, weakness ir numbness, or any other musculoskeletal pain or disorder ☐ Yes ☐ No

d) Digestive System Disorder, Liver Disease/Disorder including Hepatitis ☐ Yes ☐ No

e) Mental, nervous, emotional or neurological disorder including depression, anxiety, attention deficit disorder or stress ☐ Yes ☐ No

f) Alcohol or drug abuse, or any addiction ☐ Yes ☐ No

g) Allergies, asthma, bronchitis, respiratory disorder, shortness of breath or sleep apnea ☐ Yes ☐ No

h) Immune disorder including testing for acquired immune deficiency syndrome (AIDS), human immunodeficiency syndrome (HIV) ☐ Yes ☐ No

i) Arthritis, rheumatism, or rheumatoid arthritis ☐ Yes ☐ No

j) Cancer, tumour, cyst, polyp or any growth ☐ Yes ☐ No

k) Skin disorder ☐ Yes ☐ No

l) Breast disorder, menopause, reproductive disorder, infertility or assisted conception ☐ Yes ☐ No

m) Bladder, kidney or prostate disorder or other genitourinary disorder ☐ Yes ☐ No

n) Headaches or migraines ☐ Yes ☐ No

o) Diabetes, endocrine disorder, pituitary or thyroid disorder or lupus ☐ Yes ☐ No

p) Eye or ear disorder

q) Any other complaint, condition, disease or disorder ☐ Yes ☐ No

Please specify _____

_____

2. Have you, your spouse or any listed dependant ever been treated for, hospitalized for or had any known physical impairment, congenital abnormality, medical condition, injury, disease or disorder not stated above? Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No Dependant ☐ Yes ☐ No

3. Have you, your spouse or any listed dependant ever been advised to have an investigation, hospitalization or surgery which has not been completed, or are awaiting tests or test results?
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No Dependant ☐ Yes ☐ No

If you, your spouse or any listed dependant answered "Yes" to any of Questions 1 to 3 of Section B, please give explanation below:

| Question No. | Name of individual with condition | Illness / condition / diagnosis | Date diagnosed | Duration | Name and address of Qualified Health Care Practitioner and/or hospital providing treatment | Current status of condition |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

4. Are you, your spouse or any listed dependant currently using, expecting to use in the next 3 months or have you or they discontinued use of in the last 3 months any drug, medication, serum or other treatment? ☐ Yes ☐ No
If "Yes", please complete the table below:

| Name of Individual | Name of the drug / medication / serum / treatment | Condition being treated | Strength and daily dosage of the drug / medication / serum | Monthly cost | Length of time on this drug / medication / serum / treatment |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

5. Have you, your spouse or any listed dependant, natural parents, brother(s), sister(s), either living or dead, ever suffered ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, or retinitis pigmentosa? ☐ Yes ☐ No If "Yes", please complete the table below:

| Name of Individual | Family Member (Relationship to Proposed Insured) | Condition | Age at Onset | Age if Living | Age at Death | Cause of Death |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

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## SECTION B • MEDICAL QUESTIONNAIRE (Cont.)

6. Have you, your spouse or any listed dependant participated in the last 3 years or do you or they expect to participate in any activities of a hazardous nature including, but not limited to: motorized vehicle racing, skin or scuba diving, sky diving, mountain climbing, hang-gliding, or any other hazardous activity? ☐ Yes ☐ No

   If "Yes", please indicate the name of the activity and the person to whom it applies: _____

7. Do you, your spouse or any listed dependant intend to fly other than as a passenger on a commercial airline, or have you or they flown other than as a passenger on a commercial airline within the past 3 years? ☐ Yes ☐ No

   If "Yes", please indicate the name of the person to whom this applies: _____

8. Have you, your spouse or any listed dependant in the last 3 years had your driver's licence suspended, revoked or had 3 or more moving violations? ☐ Yes ☐ No

   If "Yes" please indicate the name of the person(s) to whom this applies: _____

For any "Yes" answers to Questions 6, 7 or 8, a supplemental questionnaire will be sent to you for completion.

## APPLICANT'S DECLARATION • ALL APPLICANTS MUST COMPLETE THIS SECTION

I/We hereby acknowledge that the statements contained herein are true and complete and, together with any other forms signed by me/us in connection with this application, form the basis for any policy issued hereunder. I/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that insurance will take effect on the date my/our properly completed application and the first premium are received by Manulife, subject to the approval of the company's underwriters. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any 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 any such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We authorize Manulife to hold a personal file about myself, my spouse and/or child(ren) and my insurance coverage. Further, I/we authorize Manulife, the Policyholder and its authorized staff, as well as its agents, representatives, and advisors to use the information collected as required in the financial management, administration and payment of insurance benefits. I/We authorize Manulife, 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 call or write to Manulife at the telephone number or address shown on this document. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application, may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality and the Notice on Exchange of Information (see brochure). I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

Signature of Member _____ Dated DD / MM / YYYY _____ Signed at (City/Province) _____

Signature of Spouse _____ Dated DD / MM / YYYY _____ Signed at (City/Province) _____

**Questions? Call toll-free 1866 219.4245**
**or e-mail us at: am_service@manulife.com**
**CPAselectplans.com**

Please send your completed Insurance application to:
Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8

* CPA Select is an official mark of the Chartered Professional Accountants of Ontario.



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