The Manufacturers Life Insurance Company
CPA Select* Insurance Plans

APPLICATION FOR DISABILITY INSURANCE

Section 1: Applicant Information

Applicant is a member of the Chartered Professional Acccountants of Membership No.:

Last Name First Name Initial

Home Address Unit/Apt. City Province/ Territory Postal Code

Date of Birth DD/MM/YYYY Place of Birth (province, country)

Preferred Contact Phone Number Email

☐ Male ☐ Female ☐ Smoker ☐ Non-Smoker*

*Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products, including e-cigarettes, in the past 12 months.

Section 2: Amount of Insurance Requested

I am applying for: ☐ New coverage ☐ Additional coverage

Income Protection (Do not include coverage already in force.)

A. Please indicate the monthly benefit amount you are applying for in $100 increments (minimum $500, maximum $15,000): **$**

B. Choose a Waiting Period before benefits begin: ☐ 0–7 days ☐ 14 days ☐ 30 days ☐ 90 days ☐ 119 days ☐ 180 days ☐ 365 days

Note: If you are covered by Employment Insurance, select a Waiting Period of 90 days or longer

☐ Add the Own Occupation Option to all Income Protection coverage applied for.***

☐ Add Future Insurability Option (FIO) to new coverage applied for.

Office Overhead Expense

A. Please indicate the monthly total reimbursement benefit amount you are applying for in $100 increments (maximum $10,000): **$**

B. Choose a Waiting Period before benefits begin: ☐ 7 days ☐ 14 days ☐ 30 days

C. Choose a Benefit Period: ☐ 6 months ☐ 12 months ☐ 18 months ☐ 24 months

☐ Add Own Occupation Option to all Office Overhead Expense coverage applied for.***

*** For details on applying for the Own Occupation Option for existing Income Protection or Office Overhead Expense Insurance, refer to the enclosed brochure or go online to **CPAselectplans.ca**.

Section 3: Other Insurance Information

Do you have any pending or existing disability income replacement or business overhead expense insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Company Name	Coverage Amount	Type of Insurance	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 (other than coverage you may have through an employer group benefits plan), do not cancel your existing coverage. In Quebec, a replacement form or declaration may be required. We may not be able to issue an insurance policy if replacement is indicated.

Section 4: Beneficiary Information

Beneficiary on the Applicant Death Benefit

I (the Applicant) hereby designate the individual(s) named below to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary(ies):

1. Last Name First Name

   Relationship to the Applicant % of Benefit

2. Last Name First Name

   Relationship to the Applicant % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

1. Last Name First Name

   Relationship to the beneficiary % of Benefit

For Quebec residents only: In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Section 5: Financial Information

A. Your employment status: ☐ Employee (no ownership) ☐ Self-employed

B. Occupational duties (give description of duties and percentage of time performing each):

C. If self-employed, what is the organizational structure of your business?
☐ Sole proprietor ☐ Partnership ☐ Corporation If incorporated, give percentage of ownership: %

D. How long have you been self-employed? Since MM/YYYY

E. If self-employed less than two years, give details of previous employment history, if any:

F. How many hours do you work per week?

G. Do you have any part-time or other full-time jobs? ☐ Yes ☐ No
If yes, provide details:

H. Do you expect your income or employment situation to change within the next 12 months? ☐ Yes ☐ No
If yes, provide details:

I. What is your share of Average Monthly Overhead Expenses, not including salary paid to yourself? $
(Complete only if self-employed and applying for Office Overhead Expense):

Section 5: Financial Information (continued)

Complete the following only if applying for Disability Income Insurance Plan

A. What was your Net Annual Earned Income (after regular business expenses but before taxes)?
   Last year: $ Two years ago: $

B. Is your net worth (assets minus liabilities other than personal use assets such as residence, automobile, jewelry) greater than $5,000,000? ☐ Yes ☐ No

C. Do you have any income which will become payable or continue should you become disabled? ☐ Yes ☐ No

D. If yes, indicate annual amount and source:

E. Is your unearned or investment income for last year greater than $30,000 or 15% of your insurable Net Annual Earned Income? ☐ Yes ☐ No

F. Are you eligible for employment insurance? ☐ Yes ☐ No

Complete the following only if applying for Business Overhead Expense Insurance Plan

A. Please indicate the monthly total reimbursement benefit amount you are applying for in $100 increments: $

B. What are your total monthly business expenses? $

C. Do you share office expenses? ☐ Yes ☐ No
   If yes, what is your percentage share? %

Proof of Income:

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

Section 6: Health Declaration

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 prognosis.

Applicant's Name Applicant's Phone Number

Physician's Name Physician's Phone Number Date last seen DD/MM/YYYY

Reason and result of last consultation.

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

Height (include ft & in or cm): Weight (include lb or kg):

Has your weight changed by more than 10 lbs (4.5 kg) in the past 12 months? ☐ Yes ☐ No

If yes: ☐ Gained (include lb or kg): ☐ Lost (include lb or kg):

Reason for change:

Section 7: Personal Information

Please ensure all questions are answered and details provided. If you require additional space, please use a separate page, signed and dated.

Have you:

	Applicant YES	Applicant 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. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked:	☐	☐
b) Within the past 2 years, been charged with or convicted of 2 or more moving or traffic violations (for example, speeding, failure to stop, seat belt violations, distracted driving or failure to provide a breathalyzer sample)? If yes, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province/territory:	☐	☐
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: a) Any expectation to travel outside Canada and the United States of America? If yes, give details including where, when, why and for how long:	☐	☐
b) Any expectation to change your country of residence? If yes, provide details, including where you intend to move, when you are moving, why you are moving and if your occupation is changing:	☐	☐
5. Within the past 5 years: a) Used any drugs other than for medical purposes; used marijuana; or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug(s) used, alcohol type(s), daily consumption and date(s) last used:	☐	☐
b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details:	☐	☐
c) Declared, or are you currently contemplating personal or business bankruptcy? If yes, provide details including date of discharge:	☐	☐

Section 8: Your Medical Information

	Applicant YES	NO
1. Have you ever had any indication of or been treated for conditions involving any of the following:		
a) **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐	☐
b) **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐	☐
c) **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐	☐
d) **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐	☐
e) **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐	☐
f) **Your brain or nervous system** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐	☐
g) **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐	☐
h) **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐	☐
i) **Your blood or glands**, such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐	☐
j) **Your muscles, bones or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints or spine causing any physical limitations or restrictions, or other?	☐	☐
k) **Your skin,** such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size or colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐	☐
l) **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐	☐
m) **Cancer**, cysts, lumps, polyps, or tumour?	☐	☐
n) **Other illness or disorder** not mentioned above, or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐	☐
2. If female,		
a) are you currently pregnant?	☐	☐
If yes, give your due date and the name and address of your obstetrician/gynecologist:		
b) What was your pre-pregnancy weight? (include lb. or kg.)		
c) Have there been any complications with your pregnancy? If yes, provide details:	☐	☐
3. During the past five years, have you:		
a) Been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain, sciatica, or other?	☐	☐
b) Had X-rays (including of the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐	☐
c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐	☐
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	☐	☐
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	☐	☐

Section 8: Your Medical Information (continued)

	Applicant YES	Applicant NO
4. Within the past 2 years, have you:		
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐
b) Consulted a specialist or been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	☐	☐
c) Been advised to undergo further investigation, see another doctor or have surgery?	☐	☐
d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐

If you answered yes to any part of questions 1, 2, 3 or 4, please give details below:

Question No.	Nature of Disorder	Date & Duration	Treatment & Current Status (If none, state "None")	Attending Physician or Hospital

Please note that, based on your health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

Family Medical History

	Applicant YES	Applicant NO
5. Have any of your parents or siblings (brothers or sisters):		
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐
b) 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?	☐	☐

If you answered yes to 5.a) or b) above, please complete the following:

Family Member	Condition (If cancer, specify type)	Age at Onset	Age at Death & Cause, if applicable

For Quebec residents only:

If you are mailing your Health Declaration to Manulife separately, please complete the following:

Applicant's Last Name First Name Initial Telephone

Section 9: Payment Information

Method of Payment

To apply securely using your credit card, contact our licensed insurance advisors at **1 866 219-4245** and/or visit **CPAselectplans.ca**.

☐ **Annual**

My cheque is enclosed, made payable to Manulife **(ANNUAL only)**

$		X		+		= $	
	Total monthly premium		No. of months to June 1 (excluding present month)		Provincial sales tax if applicable		**AMOUNT PAYABLE TO NEXT JUNE 1**

☐ **Monthly**

By pre-authorized debit – PAD (please enclose a sample cheque marked "VOID")

We'll calculate the provincial sales tax (if applicable), as well as any volume discounts you may be eligible for.

For your convenience, if you choose payment by pre-authorized debit or credit card, your future premium billings will automatically reflect the same payment method.

Payment Information

For pre-authorized debit (PAD) payment option

Name of Account Holder Financial Institution

Address of Financial Institution 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/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.

Payment authorization for pre-authorized debit (PAD) payment options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account on the day on which insurance premiums are due or after 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 10 days 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 in Rule H-1. 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.

You may obtain a sample cancellation form by contacting your financial institution or through www.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-866-219-4245 or am_service@manulife.com, or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, ON 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

Account holder address (if different from applicant)

Information about MIB, Inc.

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, Inc. based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, Inc. is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, Inc. will share any information it has on file.

You may review the information in your file, and request a correction if necessary, by contacting MIB, Inc. at:

MIB, Inc.
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

Personal Information Statement

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract, the insured providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- Identifying information such as your name, address, telephone number(s), email address, date of birth or driver's licence
- A personal investigation, financial information, credit bureau report and/or a consumer report from any organization, person or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Other personal information we may require to administer our business relationship with you
- Medical information that any organization or person has about you
- Any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test
- Your personal information from MIB, Inc., as explained in Information about MIB, Inc.
- A copy of all driving-related information from provincial or territorial Motor Vehicle Divisions

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your policy now, and in the future
  - Public sources, such as government agencies and Internet sites

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the policy
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons, financial institutions and other parties with whom we deal in issuing and administering your policy now, and in the future
- Authorized employees, agents and representatives
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your medical doctor
- Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:

- Will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- Will be shared with all the owners and any subsequent owners of those contracts and all people to be insured

How long do we keep your information?

The longer of:

- The time period required by law and by guidelines set for the financial services industry, and
- The time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the policy unless federal or provincial/territorial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care centre at 1-877-268-3763, or write to the Privacy Officer at the address below.

Accuracy and access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question or a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
P.O. Box 1602
500 King Street North
Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

A copy of our privacy principles and practices is available at manulife.ca.

Declaration and Authorization – Please read carefully before signing.

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

I (the member) understand and agree that if I am no longer a member of at least one of the participating bodies from New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island or Bermuda, for any reason whatsoever, any new or additional coverage issued pursuant to this application, together with any previously issued coverage under the Plans will be terminated. I (the member) understand that it is my responsibility to inform Manulife if my membership terminates.

I declare that the statements contained in this application, including the health declaration originally attached hereto, are true and complete. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any certificate or additional coverage issued hereunder. The person to be insured understands that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I understand that exclusions and limitations apply to the coverage applied for. Suicide within the first two years is a risk not covered. Relative to the insurance applied for, I, the person to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB, Inc., 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 or my health or the health of any member of my family to be insured pursuant to this application to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose.

I authorize Manulife, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me their products or services. I understand that my consent to the use of such information to offer me products or services is optional, and that if I wish to discontinue such use, I may write to Manulife 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 and confirm my agreement with the Declaration and Authorization, Information about MIB, Inc. and Personal Information Statement.

I (the Applicant) hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my death.

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. 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.

I acknowledge that 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 me. I further acknowledge that results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law, and that based on my health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

I acknowledge that coverage will take effect on the date the properly completed application (including my properly completed health declaration) and the first premium are received by Manulife, subject to the approval of the Company's underwriters. If I am approved, I will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am not insurable, a full refund of the premiums will be made.

By providing your email address herein, you consent to us providing information or documents to you in respect of this application or policy, as applicable, in electronic form.

Signature of Applicant _____ Dated DD/MM/YYYY Signed at City, Province/Territory

For more information about these and other CPA Select Plans plans or to apply,
visit the website at **CPAselectplans.ca** today.

For personal service, call us toll-free at **1 866 219-4245**
Monday to Friday, 8 a.m. to 8 p.m.
or email **am_service@manulife.com**.

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

Accessible formats and communication supports are available upon request. Visit **manulife.ca/accessibility** for more information.

Manulife

Underwritten by **The Manufacturers Life Insurance Company (Manulife).**

20_141028 12/2020 AC 20134 001 W2DPD AF1552