



# CPA Select Health & Dental Plan Application

Please send your completed application form, along with payment to:

**Manulife, P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8**

H41

All applicants must complete Parts A, B, C, D and E.

All applicants must complete and sign the Applicant's Authorization and Declaration.

## Part A – General Information

### Primary Applicant

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

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

Apt. Number \_\_\_\_\_ Street Number and Name \_\_\_\_\_

City or Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Office Telephone ( ) \_\_\_\_\_

Email (optional) \_\_\_\_\_

If additional information is required, how may we contact you?  Home  Office  Email

Primary Applicant is a member of the Chartered Professional Accountants of:

Ontario  Bermuda  New Brunswick  Nova Scotia  Prince Edward Island  Newfoundland and Labrador

Membership Number: \_\_\_\_\_

### Co-Applicant

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Email (optional) \_\_\_\_\_

If additional information is required, how may we contact you?  Telephone  Email

\*All applicants must have coverage under a provincial/territorial health 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.

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

If yes, please indicate:

#### Primary Applicant

Group Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Date Benefits Ended \_\_\_\_\_ (dd/mm/yyyy)

#### Co-Applicant

Group Plan Number \_\_\_\_\_ ID Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Date Benefits Ended \_\_\_\_\_ (dd/mm/yyyy)

**Note: When you apply for insurance, your beneficiary is set as your estate. In your welcome package, you'll find a form that you can use to change your beneficiary.**

# The Manufacturers Life Insurance Company

## Part B – Plan Choice

I/We apply for the following Plan – Note that your Plan Choice applies to all family members.

- CPA Select Starter Health & Dental\*  
 CPA Select Essential Health      or      CPA Select Essential Health & Dental  
 CPA Select Enhanced Health      or       CPA Select Enhanced Health & Dental

### Add-Ons

- CPA Select Essential Catastrophic Rider  
 CPA Select Enhanced Catastrophic Rider

\*This plan does not require completion of the Medical Questionnaire in this application.

## Part C – Individuals to be Covered

Last Name	First Name	Code	Sex	Birth date DD/MM/YYYY	Age	Smoker? No. Of Cigarettes Daily	Height	Weight	Weight change in last year gain    loss	Reason for weight change
		00								
Applicant		01								
Co-Applicant		02								
Dependant		02								
Dependant		02								
Dependant		02								
Dependant		02								

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

## Part D – Payment Options

**Initial Payment:** I/We hereby authorize Manulife to debit the initial two (2) months' premium, \$ \_\_\_\_\_, using my/our:

- Option #1     Pre-Authorized Debit (PAD)  
 Option #2     Credit Card Account

**IMPORTANT:** Initial payment will be taken on the day approved (not the effective date). Future payments will be taken on the first of each month.

Subsequent payments will be made by:

- Option #1     Pre-Authorized Debit (PAD)  
 PAD Billing Frequency:     Monthly       Semi-Annual (2% savings)       Annual (4% savings)

**Important:** For verification purposes, we require a sample cheque marked 'VOID'. Please complete Part E.

- Option #2     Credit Card Account  
 Credit Card Billing Frequency:     Monthly       Semi-Annual       Annual

**Please note:** Billing frequency savings are not available for credit card payment options. Please complete Part E.

- Option #3     Direct Billing  
 Direct Billing Frequency:     Semi-Annual (2% savings)       Annual (4% savings)

## Part E – Payment Information and Authorization

### Credit Card Option Payment Information & Payment Authorization

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.

Credit Card:  Visa  MasterCard  American Express

Card Number \_\_\_\_\_ Expiry Date \_\_\_\_\_ (mm/yyyy)

Name of Cardholder \_\_\_\_\_ Signature of Cardholder \_\_\_\_\_

Dated \_\_\_\_\_ (dd/mm/yyyy)

### Pre-Authorized Debit (PAD) Payment Information & Payment Authorization

Please use the following banking information:

From the cheque used to make the first payment **or**

As follows (only complete the information below if you do not have a void cheque):

Name of Account Holder \_\_\_\_\_

Transit Number \_\_\_\_\_ Institution Number \_\_\_\_\_ Bank Account Number \_\_\_\_\_

Financial Institution \_\_\_\_\_ Address of Account Holder \_\_\_\_\_

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 Pre-Authorized Debit (PAD) Payment Options

I/We hereby authorize Manulife to make a withdrawal from my/our bank account on the day on which insurance premiums are due for insurance premiums due on 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 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 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](http://www.payments.ca). If you have any questions about withdrawals from your bank account, contact us at 1-800-268-3763 or [more\\_info@manulife.com](mailto:more_info@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](http://www.payments.ca).

Signature of Account Holder \_\_\_\_\_ Dated \_\_\_\_\_ (dd/mm/yyyy)

Second Signature if Joint Account \_\_\_\_\_ Dated \_\_\_\_\_ (dd/mm/yyyy)

Account Holder Address (if different from Applicant) \_\_\_\_\_

# CPA Select Medical Questionnaire

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 and receipt of first premium payment.

**All applicants must complete and sign the Applicant's Authorization and Declaration.**

**Additional medical information may be required to underwrite your application. If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.**

## Section A – Treating Qualified Health Care Practitioner

**Must be completed in full for all plans except for the CPA Starter Health & Dental Plan.**

Name and address of present physician or qualified health care practitioner (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 Applicant	For Co-Applicant	For Dependand(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 primary health care provider consulted or referred to:

\_\_\_\_\_

Date and reason for consultation: \_\_\_\_\_

To which individual applying for coverage does this apply? \_\_\_\_\_

## Section B – Simplified Underwriting Questionnaire

**Must be completed in full for all plans except for the CPA Starter Health & Dental Plan.**

Have you, your co-applicant or any listed dependand(s):

- Been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years?  Yes  No
  - Consulted or been advised to consult a qualified health care practitioner about or had any known indication of a medical condition or complaint within the last year?  Yes  No
  - Sustained any injury or been treated for any medical condition that requires or has required the services of a qualified health care practitioner at least once per year within the last 2 years?  Yes  No
  - Been advised to use a medication or treatment for a chronic and/or recurring medical condition?  Yes  No
    - Used any medication or treatment for 20 or more days within the past year?  Yes  No
    - Expect to use any medication or treatment within the next 3 months?  Yes  No
- Note: Medications used for birth control or to treat minor ailments like a cold or flu are not to be considered when answering this question.
- Been diagnosed with any medical illness, condition or disease, or been advised by a qualified health care practitioner to have an investigation, surgery or seek hospitalization? (Do not include any minor ailments such as a cold or flu.)  Yes  No

If you answered "Yes" to any question in section B, please complete section C below in full. If applying for Catastrophic Coverage, please complete sections C and D below.

# Section C – Medical Declaration

**Must be completed in full for all plans except for the CPA Starter Health & Dental Plan.**

**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.

1. Have you, your co-applicant or any listed dependant(s) 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 or 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 or knee pain or disorder, fibromyalgia, osteoporosis, osteopenia, chronic pain, paralysis, weakness or numbness, or any other musculoskeletal pain or disorder?  Yes  No
  - d) Digestive system disorder, Crohn’s disease, ulcerative colitis, liver disease or disorder including hepatitis or hepatitis carrier state?  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 virus (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?  Yes  No
  - q) Any other complaint, condition, disease or disorder?  Yes  No

Please specify: \_\_\_\_\_  
 \_\_\_\_\_

2. Have you, your co-applicant or any listed dependant(s) ever been treated for, hospitalized for or had any known physical impairments, congenital abnormality, medical condition, injury, disease or disorder **not stated above**?  Yes  No
3. Have you, your co-applicant or any listed dependant(s) ever been advised to have an investigation, hospitalization or surgery which has **not been completed**, or are awaiting any tests or test results?  Yes  No
4. Have you, your co-applicant or any listed dependant(s) ever been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years?  Yes  No
5. If you answered “Yes” to any question in section C, please give explanation below:

Question Number	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
			(dd/mm/yyyy)			
			(dd/mm/yyyy)			
			(dd/mm/yyyy)			
			(dd/mm/yyyy)			

## Section C – Medical Declaration (continued)

6. Are you, your co-applicant or any listed dependant(s) currently using or expecting to use in the next 3 months, or have you discontinued using in the last 3 months any drug, medication, serum or other treatment?  Yes  No

If yes, provide details below:

Name of Individual	Name of the Drug/Medication/Serum/Treatment	Condition Being Treated	Strength and Daily Dosage of the Drug/Medication/Serum	Length of Time on this Drug/Medication/Serum/Treatment

7. Are you, your co-applicant or any listed dependant(s) pregnant?  Yes  No

If yes, name of pregnant individual(s) \_\_\_\_\_ Due date \_\_\_\_\_

## Section D – Catastrophic Medical Questionnaire

**Must also complete Sections A and C when applying for the Catastrophic Coverage Rider.**

(Available as an Add-On)

1. Have you, your co-applicant or any listed dependant(s), natural parents, brother(s), sister(s), either living or dead, ever suffered from any of the following conditions: heart disease, stroke, cancer (specific type), 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 section below.

Name of Individual	Relationship to Proposed Insured	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death

2. Have you, your co-applicant or any listed dependant(s) participated in the last 3 years or 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 sports or activities?  Yes  No

If yes, please indicate the name of the avocation(s)/sport(s) and person(s) to whom it applies:

\_\_\_\_\_

3. Do you, your co-applicant or any listed dependant(s) intend to fly other than as a passenger on a commercial airline, or have flown other than as a passenger on a commercial airline within the past 3 years?  Yes  No

If yes, please provide the name of the person(s) to whom this applies: \_\_\_\_\_

4. Have you, your co-applicant or any listed dependant(s) in the last 3 years had their driver's licence suspended, revoked or had 3 or more moving violations?  Yes  No

Driver's licence number(s) \_\_\_\_\_

If you answered "Yes" to any of the questions above, a supplemental questionnaire will be sent to you for completion. If you require more space to complete any part of this application, please attach a separate sheet, signed and dated.

# Personal Information Statement

In this Statement, “you” and “your” refer to the plan member or holder of rights under the contract, the insured and the parent or guardian of any child named as insured who is under the legal age for 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](http://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
- Medical information that any organization or person has about you
- A copy of all driving-related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or consumer report from other organizations, persons or sources that have any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Banking data to administer benefits
- Other personal information we may require to administer our business relationship with you

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 plan now, and in the future
  - Public sources, such as government agencies and internet sites
  - Health care professionals, including medical practitioners, health care institutions, pharmacies and any other medically related facility
  - Other insurance carriers
  - Administrators of government benefits and other benefit programs

## 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 plan
- 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 and other parties with whom we deal in issuing and administering your plan 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, and paramedical and investigative agencies)
- Your medical doctor

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.

## 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 plan unless federal or provincial laws give you this right. If you do so, a plan 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  
500 King Street N  
P.O. Box 1602  
Waterloo, ON N2J 4C6**

[Privacy\\_office\\_canadian\\_division@manulife.com](mailto: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.

# Applicant's Authorization and 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 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 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. 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. 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 Manulife's Personal Information Statement. I/We understand and agree that coverage shall not become effective until the first of the month following final approval and receipt of the first premium payment.

A photocopy of this signed authorization shall be as valid as the original.

Signed at \_\_\_\_\_ Signature of Primary Applicant \_\_\_\_\_ Dated \_\_\_\_\_ (dd/mm/yyyy)

Signed at \_\_\_\_\_ Signature of Co-Applicant \_\_\_\_\_ Dated \_\_\_\_\_ (dd/mm/yyyy)

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Please send the completed application to:

<b>Regular Mail:</b> Manulife P.O. Box 670 Stn Waterloo Waterloo, ON N2J 4B8	<b>Courier:</b> Manulife 500 King Street Affinity Markets New Business Delivery Station 500-GB Waterloo, ON N2J 4C6	<b>Fax:</b> 1 888 264.2243
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 [www.cpaselectplans.com](http://www.cpaselectplans.com)

 [am\\_info@manulife.com](mailto:am_info@manulife.com)

 1 866 219.4245



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