

APPLICATION FOR PROFESSIONAL POOL INSURANCE

Caroline Hancock
 c/o McFarlan Rowlands Insurance Brokers
 1570 Hyde Park Rd.
 London ON N6H 5L5 1-866-471-7152



The Manufacturers Life Insurance Company

Member Information *(Please print)*

I am a member of: (Professional Association Name)			
Last Name	First	Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	Province Postal Code
Date of Birth	Country of Birth		
E-mail		Tel. (Home)	(Bus.)
Occupation	Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please describe the nature of your business and duties in the space provided above.

AF 1182E (02/2008)

Spouse Information *(Complete only if applying for Spousal Coverage)*

Last Name	First	Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	Province Postal Code
Date of Birth	Country of Birth		
E-mail		Tel. (Home)	(Bus.)
Occupation	Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please describe the nature of your business and duties in the space provided above.

Child Information *(Complete only if applying for Child Coverage)*

Name of Child	Gender	Date of Birth	Height	Weight	Name and Address of Family Doctor
	<input type="checkbox"/> M <input type="checkbox"/> F	DD/MM/YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kgs	
	<input type="checkbox"/> M <input type="checkbox"/> F	DD/MM/YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kgs	

If more space is needed, complete a separate sheet, signed and dated.

Other Insurance Information

Do you (Member or Spouse) have any existing insurance coverage with Manulife Financial or any other company? Yes No If "Yes", please complete the following:

Name of Applicant	Company Name	Type of Insurance (life, disability, office overhead)	Amount	Elimination Period (for disability)	Benefit Period (for disability)	Non-taxable or taxable? (for disability)	Do you intend to replace this coverage?
			\$				<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$				<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$				<input type="checkbox"/> Yes <input type="checkbox"/> No

If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new Professional Pool contract.

OMTA 93609001 WCEF8	Geomatics 21107001 WCEF8	Denturists 34101001 WCEF8	CSC 95307001 WCEF8	CMTA 35201001 WCEF8	CASLPA 32302001 WCEF8	AMCTO 21305001 WCEF8	Physicists 21406001 WCEF8
AMTWP 95405001 WCEF8	Psychological 22906001 WCEF8	Physiotherapy 23013001 WCEF8	CAOT 92410001 WCEF8	Planners 24203001 WCEF8	CIPHI 33001001 WCEF8	Ophthalmological 23106001 WCEF8	

Insurance Plan Choices

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

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

Member: Smoker Non-Smoker¹

Spouse: Smoker Non-Smoker¹

¹ Non-Smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife Financial's health standards.

TERM LIFE INSURANCE (SAVE 10% on premiums for \$200,000 of coverage)

Member	Amount of coverage applied for \$ _____ Available from \$25,000 to \$750,000 in increments of \$25,000
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Spouse	Amount of coverage applied for \$ _____ Available from \$25,000 to \$750,000 in increments of \$25,000
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CHILD LIFE AND ACCIDENT INSURANCE

One monthly premium of \$2.25 covers ALL your eligible children for \$10,000 of life coverage each. <input type="checkbox"/> Yes
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PERSONAL ACCIDENT INSURANCE

Member Available if you participate in the Member Term Life Plan. Amount of coverage applied for (check one only) Monthly Premium	Up to \$100,000 \$6 <input type="checkbox"/>	Up to \$150,000 \$9 <input type="checkbox"/>	Up to \$200,000 \$12 <input type="checkbox"/>	Up to \$250,000 \$15 <input type="checkbox"/>	Other amount \$ _____ <input type="checkbox"/>
Spouse Available if you participate in the Spouse Term Life Plan. Amount of coverage applied for (check one only) Monthly Premium	Up to \$100,000 \$6 <input type="checkbox"/>	Up to \$150,000 \$9 <input type="checkbox"/>	Up to \$200,000 \$12 <input type="checkbox"/>	Up to \$250,000 \$15 <input type="checkbox"/>	Other amount \$ _____ <input type="checkbox"/>

MEMBER INCOME PROTECTION DISABILITY INSURANCE

Amount of coverage applied for \$ _____/month Available from \$100 to \$5,000 in increments of \$100	Waiting period <input type="checkbox"/> 30 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days
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OFFICE OVERHEAD EXPENSE INSURANCE

Amount of coverage applied for \$ _____/month Available from \$100 to \$5,000 in increments of \$100	Waiting period <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days
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Financial Information (Complete only if applying for Income Protection Disability Insurance and/or more than \$250,000 of Term Life Insurance)

Member Annual Net Income, after expenses but before tax \$ _____ Personal Net Worth (assets less liabilities) \$ _____	Spouse Annual Net Income, after expenses but before tax \$ _____ Personal Net Worth (assets less liabilities) \$ _____
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Terms & Conditions (Please read carefully before signing)

DECLARATION: I/We hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/We 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/us in connection with this application, form the basis for any policy or certificate issued hereunder. I/We have read and understand that there are exclusions and limitations on the coverage applied for. I/We understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date for Life Insurance is a risk not covered. I/We understand that insurance will take effect on the date my/our 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/We 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/we, the undersigned person(s) 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/us, 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/We authorize Manulife Financial to consult its existing files for this purpose. I/We authorize Manulife Financial, its subsidiaries, affiliates and agents to use this information to offer me/us their products and services. I/We understand that my/our consent to the use of this 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 Financial at the address or telephone number shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/We acknowledge receipt of, and confirm my/our agreement with, the Notice on Exchange of Information and the Notice on Privacy and Confidentiality. I/We declare that I/we 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 7 years after the termination date of any policy or certificate issued as a result of this application. I/We 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 (the member) hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any policy or certificate issued hereunder.

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

Spouse's Signature (if applying for spousal coverage) _____

Signed at (City/Town): _____ Date DD/MM/YYYY

Caroline Palmer Hancock _____

0236302 _____ Date DD/MM/YYYY

Agent of Record/Broker (if applicable) _____

Agent ID: _____ Date

Complete this section when applying for Income Protection Disability Insurance and/or Office Overhead Expense Insurance (Member only)

Employment Status: Employee Self Employed

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

If owner of a partnership or corporation, give percentage ownership: _____ %

Date you became self-employed: DD/MM/YYYY

Your share of Average Monthly Overhead Expenses (not including salary paid to yourself): \$ _____

Have you declared or are you contemplating personal or business bankruptcy? Yes No If yes, provide details including date of discharge:

Proof of Income: If applying for more than \$3,500/month of Income Protection Disability Insurance, please submit pages 1, 2 and 3 of your last 2 years' tax return. If incorporated, please also submit your last corporate financial statement.

Beneficiary Designation

Beneficiary of Member's Coverage

Last Name	First
Relationship	

In Québec, the designation of spouse as beneficiary of this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

Beneficiary of Spousal Coverage

Last Name	First
Relationship	

In Québec, the designation of spouse as beneficiary of this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

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

Underwriting Questionnaire (Both sides MUST be completed, even if all health questions are answered "NO")

Member's Physician (Name)	Telephone	Spouse's Physician (Name)	Telephone
Physician's Address		Physician's Address	
Date last seen:	Reason last seen:	Date last seen:	Reason last seen:
Tests, treatment, medication prescribed:		Tests, treatment, medication prescribed:	
Results and current status:		Results and current status:	
Member's Height <input type="checkbox"/> ft/in <input type="checkbox"/> cm	Weight <input type="checkbox"/> lbs <input type="checkbox"/> kgs	Spouse's Height <input type="checkbox"/> ft/in <input type="checkbox"/> cm	Weight <input type="checkbox"/> lbs <input type="checkbox"/> kgs

Has any individual proposed for coverage (member, spouse or child(ren)):

	MEMBER		SPOUSE		CHILD(REN)	
	YES	NO	YES	NO	YES	NO
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including name of applicant, date, name of company and reason: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 5 years, had their driver's licence suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), Driver's Licence # and licensing province: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Any intention to pilot an aircraft or participate in scuba-diving, parachuting, hang-gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including name of applicant, type of activity and date(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the next 12 months, any intention of travelling or residing outside North America? If "yes", give details including name of applicant, where, when, why and for how long: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 name of applicant, drug or alcohol type(s) and date(s) last used: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Female applicants only: Are you currently pregnant? If yes, give due date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a miscarriage, pre-eclampsia, Caesarean section or other complication of pregnancy? If yes, give date and details: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Complete both sides

