The Manufacturers Life Insurance Company

FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

SISIP Financial Term 100 (T100) Life Insurance Application Form

Please type or print in ink.

Part A — Applicant Information

You are applying as a: ☐ CAF Member (Code: M) ☐ Spouse of CAF Member (Code: S) ☐ Child of CAF Member (Code: C)

CANADIAN ARMED FORCES (CAF) MEMBER SERVICE NUMBER:

☐☐☐ ☐☐☐ ☐☐☐ ☐ M/S/C

CAF Member Service Number
(Please indicate if you are applying as a Member [M], Spouse [S] or Child [C] by entering the appropriate letter at the end of the Member Service Number)

☐ Male ☐ Female

☐ Smoker ☐ Non-Smoker*

*Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products in the past 12 months and who meet Manulife's health standards. Smoker status is determined when your coverage is approved.

Applicant Name: _____
Last First

Home Address: _____ ON
Street Unit/Apt# City Province Postal Code

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

Primary Phone Number: _____ Email: _____

Occupation: _____

Part B — Amount of Insurance Applied for (DO NOT include coverage already in force)

APPLICANT COVERAGE AMOUNT

Choose the amount of Term 100 Life Insurance coverage you require. Coverage is available in increments of $25,000. The minimum coverage amount is $25,000. The coverage in-force and applied for may not exceed $100,000.

☐ **$25,000** ☐ **$50,000** ☐ **$75,000** ☐ **$100,000** Add Waiver of Premium Option? ☐ Yes ☐ No

You must choose the Waiver of Premium Option at time of Term 100 Life Insurance application. Please see brochure for more information.

PREMIUM PAYMENT OPTIONS

☐ **Regular Premiums – pay to age 100** ☐ **20 Pay Premium Option** – pay for 20 years**

**20 Pay Option available to those 18 to 60 years of age.

EXISTING COVERAGE

Do you have any pending or existing life insurance coverage with Manulife or any other company?
☐ Yes ☐ No If yes, complete the following:

Company Name	Personal or Business	Coverage Amount	Do you intend to replace this coverage?
			☐ Yes ☐ No
			☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated. If you are replacing a portion of your existing SISIP Financial term life insurance, no replacement form is needed.

Part C – Beneficiary Information

APPLICANT

I hereby designate the individual(s) named as beneficiary(ies) on this application 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 You, the Applicant _____ % of Benefit _____

2. Last Name _____ First Name _____ Relationship to You, the Applicant _____ % of Benefit _____

Contingent Beneficiary(ies):

1. Last Name _____ First Name _____ Relationship to You, the Applicant _____ % of Benefit _____

2. Last Name _____ First Name _____ Relationship to You, 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:

Name (Last/First) _____ Relationship to the Beneficiary _____

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.

Part D – Personal Information

Have you: YES | 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 two 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: ☐ ☐

3. a) Within the past 5 years, used any drugs for other than medical purposes, used marijuana, or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug used, alcohol type(s), daily consumption and date(s) last used: ☐ ☐

   b) Within the past 5 years, been convicted of a criminal offence or are you currently charged with one? If yes, please provide details: ☐ ☐

   c) Within the past 5 years, declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge: ☐ ☐

Outside of your military duties as a serving member:

4. Have you 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): ☐ ☐

5. a) Within the next 12 months do you expect to travel outside of Canada and the United States of America? If yes, give details including where, when, why and for how long: ☐ ☐

   b) Do you expect 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: ☐ ☐

Part E – Your Health Declaration

Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.) Quebec residents may detach this declaration page and send it directly to Manulife at the address shown on this application.

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.

Your Name _____ Telephone _____

Physician's Name _____ Physician's Telephone _____

Physician's Address _____ _____ _____ ON _____ _____
Number and Street | Unit/Suite # | City | Province | Postal Code

Date, reason and result of last consultation, and treatment or medication prescribed, if any: _____

Height _____ ☐ ft & in / ☐ cm Current Weight _____ ☐ lbs / ☐ kg

Has your weight changed by more than 10 lb (4.5 kg) in the past year? ☐ Yes ☐ No

If yes: ☐ Gained _____ ☐ lbs / ☐ kg ☐ Lost _____ ☐ lbs / ☐ kg Reason for Change

MEDICAL INFORMATION

1. Have you ever had any indication of or been treated for conditions involving any of the following: YES | NO

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, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine 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? ☐ ☐

Part E – Your Health Declaration (continued)

2. Within the past 2 years, have you:

		YES	NO
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)	Are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐

If you answered yes to any of the questions above in 1 or 2, please give details below. If additional space is needed, use a separate page, signed and dated:

Question Number	Nature of Disorder	Date and Duration	Treatment (if none, state "None") and Current Status	Attending Physician or Hospital

3. Your Family Medical History:

		YES	NO
a)	Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐
b)	Have any of your parents or siblings 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 a) or b) above, please complete the following:

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

4. Female applicants only

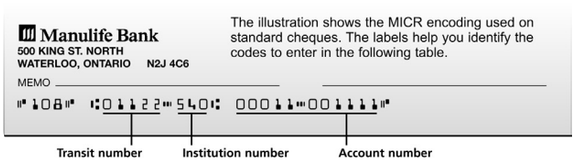
		YES	NO
a)	Are you currently pregnant?	☐	☐
	If yes, give due date and the name and address of your obstetrician/gynecologist:		
b)	What was your pre-pregnancy weight? ☐ lbs / ☐ kg		
c)	Have there been any complications with your pregnancy? If yes, provide details:	☐	☐

Part F – Your Payment Method (Please select Option #1 or Option #2)

☐ **OPTION #1: MONTHLY PRE-AUTHORIZED DEBIT - PAD**
Please enclose a sample cheque marked "VOID"

☐ **OPTION #2: ANNUAL PAYMENT BY CHEQUE**
Please enclose a cheque payable to Manulife

Annual (please enclose a cheque payable to Manulife)



Part G – Payment Information and Authorization

PAYMENT INFORMATION | FOR PRE-AUTHORIZED DEBIT (PAD) PAYMENT OPTION

Name of Account Holder _____ Financial Institution _____

Address _____ City/Town _____

Bank Account Number _____ Branch 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 OPTION

I/We authorize Manulife to withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date I/we sign this authorization. I/We authorize Manulife to withdraw premiums **on or about the first business day of** each month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and 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 my/our 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 me/us for an alternate method of payment if my/our 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 H1. I/We and/or Manulife can end this agreement at any time by giving **10 days' written notice**. I/We understand that cancelling this PAD agreement may result in a 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.payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-855-887-7809, am_service@manulife.com or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

Part G – Payment Information and Authorization (continued)

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, you may 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 _____ ON _____
(if different from Applicant) Number and Street Unit/Suite # City Province Postal Code

Part H – Notice on Exchange of Information

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, ON M5G 1R7. The insurer, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

Part I – Notice on Privacy and Confidentiality

The specific and detailed information requested on your Application Form is required to process your application. To protect the confidentiality of this information, Manulife will establish a financial services file from which this information will be used to process your application(s), offer and administer services and process claims, relative to the insurance applied for. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you other products and services which are endorsed or sponsored by SISIP Financial is optional, and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn. 500-4-A, Waterloo, ON N2J 4C6.

Part J — Declaration and Authorization (Please read carefully before signing)

I hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I declare that the statements contained in this application are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any policy issued hereunder. I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer, and that suicide within two years of the effective date is a risk not covered. I understand that other exclusions and limitations will apply to the coverage applied for. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, MIB, Inc., any insurance company, agent, broker, market intermediary, plan sponsor, group policy administrator 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 or my health, to provide such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I further authorize Manulife to consult this application and its existing files for this purpose. I understand that in connection with this application, Manulife may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant, and that any positive infectious disease results will be reported to the appropriate health department if required by law. I declare that I understand the reason why the health information is needed and the risks and benefits of consenting or refusing to consent.

I understand that insurance will take effect on the date my properly completed application (including the health declaration) and the first premium are received by Manulife, subject to approval of the company's underwriters. If my application is approved, I will receive a policy specifying the coverage provided and the main policy provisions.

I hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds in accordance with any certificate/policy issued hereunder.

I acknowledge receipt of and confirm my agreement with the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY (see Part H and Part I).

The insurer, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

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

Signed at (City, Province) _____ Date (DD / MM / YYYY) _____ Signature of Applicant _____

ADVISOR'S REPORT

You confirm that you have disclosed the following information to the applicant: Advisor Code _____

- the name of the company or companies you represent, and
- that you receive a salary for the sale of life, accident and sickness insurance products.

Your Name (first, middle initial, last) _____ Signature _____

Send your completed and signed application form along with payment to Manulife:

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

FAX:
1-888-264-2243

CUSTOMER SERVICE:

1-855-887-7809
(Monday through Friday from 8 a.m. to 8 p.m. EST)

am_service@manulife.com

SISIPT100.ca

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

Underwritten by The Manufacturers Life Insurance Company.