

Send all completed Applications and Mail for Personal Accident Disability Insurance to:

Manulife Financial
Personal Accident Department
2 Queen St. E.
Toronto, ON
M5C 3G7 (courier address)

Note: If you are contracted through a Managing General Agency or National Account Firm please forward your application to their office.

How to inquire on the status of a pending Personal Accident Disability Insurance application:

- Call toll free at 1 (888) 477-5450 or e-mail PACR_Admin@manulife.com

Premium Collection:

- The initial premium must be collected and submitted together with the application for insurance. **Coverage is not available on a COD basis.** You will need to collect the first **two monthly premiums** or one full annual premium. Cheques should be dated the same date the application is signed. Post-dated cheques are not accepted.
- If the Credit Card payment option has been selected, we will process a billing for the first 2 monthly premiums or full annual premium upon receipt of the application.
- Regular monthly pre-authorized debits and/or Credit Card billing will be processed in the 3rd month following the policy effective date on the billing date selected.

Example: Policy Effective Date = April 1st and Billing Day = 15th

Coverage Period	Premium Billing
April 1st to May 1st	Initial deposit – 1st monthly premium credited
May 1st to June 1st	Initial deposit – 2nd monthly premium credited
June 1st to July 1st	1st premium withdrawal would be processed on the 15th of June

Effective Date:

- The effective date of the policy contract will be the date the application is signed. Any applications dated the 29, 30 or 31st will be effective the 1st day of the next month.
- If Sickness Disability coverage has been applied for, the effective date for this coverage will be as follows:
 - if approved within 30 days – date the application was signed (same as Accident Coverage)
 - if approved after 30 days – the next anniversary day following date of approval

Policy Mailing:

- We will mail the policy document to you for delivery or directly to your client. Policies that are not issued as applied for, issued with exclusions or Head Office Amendments will be sent to the Advisor for delivery.

Returned Cheques – Initial Premium:

If the initial premium is returned by the bank:

- The policy will be processed as a NOT TAKEN, and commissions will be reversed.
- A letter is sent to the client (copy to agent) requesting a replacement cheque within 20 days otherwise a new application must be submitted.

Mail to: Personal Accident Department
 2 Queen St. E., P.O. Box 4213, Stn A
 Toronto, Ontario M5W 5M3

H.O. use only

Please ensure all changes/corrections are initialed by the primary insured/owner. Do not use white-out on this application.

PLEASE PRINT

Addition to Policy Number **S** _____

PART 1

A. Primary Insured Information

Please contact me at: Home Work Email _____

1. First Name	Middle Initial	Last Name	Maiden Name	H.O. use only
2. Number & Street		City	Province	Postal Code
3. Residence Telephone Number ()		4. Business Telephone Number ()		5. Date of Birth (dd/mm/yy)
6. Age		7. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		8. Social Insurance Number
9. Policy Language English <input type="checkbox"/> French <input type="checkbox"/>		10. Place of Birth		
11. Primary Occupation		12. Length of Time	13. Duties (detailed description)	
14. Name & Address of Company/Employer			15. Secondary Occupation	16. Hours per week
17. Are you a permanent resident of Canada? Yes <input type="checkbox"/> No <input type="checkbox"/> (Answer must be 'yes' to be eligible for insurance)		18. Will this insurance replace any existing income replacement insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> (Complete only if residing in Quebec. If "YES", complete required form)		
19. Beneficiary Note: In the Province of Quebec, unless stated to be revocable, a spousal beneficiary is irrevocable. If more than one beneficiary, benefits will be paid in equal shares, unless otherwise stated.			20. Relationship to Primary Insured	H.O. use only
21. Owner (Complete only if Primary Insured is a minor; otherwise the Owner is the Primary Insured.)		22. Owner's Date of Birth (dd/mm/yy)	23. Relationship to Primary Insured	H.O. use only

B. Accident Disability Plan

		Benefit Amount	Annual Premium
1. 24 Hour Compensation (2 Year Benefit)	1st Day Coverage (\$300 Minimum Required)	\$	\$

C. Accident & Sickness Disability Riders

Coverage Information – Please (✓)

		Benefit Amount	Annual Premium
2. 24 Hour Compensation (E) (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 30 Days or <input type="checkbox"/> 120 Days	\$	\$
3. Non-Occupational Loss of Income (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 0 Days or <input type="checkbox"/> 120 Days	\$	\$
4. Sickness Disability (2 Year Benefit)	Elimination Period: <input type="checkbox"/> 30 Days or <input type="checkbox"/> 120 Days or <input type="checkbox"/> 15 Day Retro	\$	\$
5. 24 Hour Accident Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$
6. Non-Occupational Accident Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$
7. Sickness Disability Extension	Benefit Period: <input type="checkbox"/> 3 Years or <input type="checkbox"/> To age 65	\$	\$

D. Additional Riders

Coverage Information & Benefit Amount – Please (✓)

		Annual Premium
1. Accidental Death & Dismemberment	Accident Death Benefit Amount: <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000	\$
2. Accident Excess Medical	Accident Paramedical Services Benefit Amount: <input type="checkbox"/> Plan A – \$400 <input type="checkbox"/> Plan B – \$600 <input type="checkbox"/> Plan C – \$800	\$
3. Return of Premium	Exclude On:	\$
4. Return of Premium on Death	Exclude On:	\$
5.		\$
Total Annual Premium (Monthly Premium = Annual Premium ÷ 12)		\$

E. Eligibility – For all Plans and Riders

Answers to Questions 1, 2a), 2b) & 3 must be “No” to be eligible for any coverage.

1. Are you currently totally or partially disabled or receiving disability benefits or a disability pension?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. a) Do you have any physical impairments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Do you have a physical impairment that limits your ability to perform your normal occupation(s) and/or engage in all of the functions of your normal daily routine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Are you currently receiving social assistance (welfare) benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

F. Employment Eligibility

Complete for benefit amounts exceeding \$500 per month AND for ANY amount of 24 Hour Accident Disability Extension, Non-Occupational Accident Disability Extension or Sickness Disability Extension.

1. Do you currently work 30 or more hours per week? (Answer must be “Yes” to be eligible).....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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G. Financial Information and Existing Insurance

Complete for benefit amounts exceeding \$1,000 per month for ANY coverage under Part 1., Section B. & C.

1. Gross Annual **Personal** Earned Income (subtract E.I./U.I.) _____ x 75% = _____ ÷ 12 = _____ / Eligible Monthly Income.

2. If self-employed Gross Annual **Business** Income _____
 – Purchases; sub-contracts; wages & salaries; investment; interest; rental & government plan incomes _____
 = Eligible Business Income _____

a) No full-time employees:
 Eligible Business Income _____ x % of ownership _____
 = _____ x 75% = _____ ÷ 12 = _____ / Eligible Monthly Income.

b) With full-time employees:
 Eligible Business Income _____ x % of ownership _____
 = _____ x 1% = _____ / Eligible Monthly Income.

3. Do you have coverage with Workers’ Compensation? (If “Yes” provide coverage amount below & integrate benefits) Yes No

4. Do you currently have Disability Insurance? (If “Yes” provide details below & integrate benefits) Yes No

Question No.	Details

PART 2

Primary Insured _____

H. Medical Questionnaire

Date of Birth _____

Complete if applying for Sickness Disability or Sickness Disability Extension.

Please circle applicable items in each question and provide details of any "yes" answer in the Details section below. If "yes" is answered to questions 1, 2 or 3, the applicant cannot be offered these riders.

	Primary Insured	
1. Have you ever been tested for, had consultations for, received treatment for, or had any known indications of: stroke, heart disorder, disorder of the brain or nervous system, Multiple Sclerosis, lupus, diabetes, tumor or cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever received medical advice or treatment in connection with, or been diagnosed for AIDS (Acquired Immune Deficiency Syndrome), or an AIDS-related condition? Have you ever been told you had a positive blood test for antibodies to the AIDS virus, or treated for enlarged lymph nodes or malignant skin lesions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Have you ever used drugs, except as prescribed by a physician, or received advice or treatment for drug addiction, alcohol use or other substance use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Other than above, have you ever been tested for, received treatment for, or had any known indication of:		
a) high blood pressure, chest pains, numbness, tingling, heart murmur, palpitations or any other disorder of the heart, blood vessels or blood?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) disorder of the eyes, ears, nose, throat or lungs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) disorder of the stomach, gall bladder, liver, hepatitis (including carrier state), pancreas or intestines, including chronic diarrhea and hernia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) disorder of the kidney, ureter, bladder, prostate, reproductive or genital organs, including any sexually transmitted disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e) disorder of the skin, muscles, bones or joints including back, neck or knee pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) disorder of the thyroid, lymph nodes, or glands, or any other infections?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g) tuberculosis, respiratory, sleep apnea, neurological, mental, emotional or nervous disorder (depression, stress or anxiety)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
h) disorder of the breast including lumps, cysts, abnormal mammogram or biopsy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever been advised to have any tests, treatment, investigations, or surgery which have NOT yet been completed or are you aware of any symptoms or indications for which you have NOT yet consulted a physician or received treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you currently been prescribed and/or are you taking prescription medication or receiving any treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Have you ever applied for disability, life, Critical Illness or Long Term Care insurance that has been declined, postponed, rated or issued with an exclusion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Have you ever received disability income insurance benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Have you been absent from work for more than 5 consecutive days within the last 12 months due to sickness or injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Other than as disclosed above have you, within the past 5 years, consulted any other physician, specialist or medical practitioners?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Height _____	12. Weight _____	13. Family Doctor's Name _____
14. Address _____		15. Telephone Number (_____) _____
16. Date last consulted a physician _____		17. Reason for consultation _____
18. Results _____		
19. Name and Address of Physician (if different from above) _____		

Details Please attach a separate sheet, signed and dated, if this section is not large enough for all details.

Question Number	Date of Occurrence	Duration	Indicate diagnosis, severity, if any recurrence? If any treatment provided? Is there any residual pain? Any time off work?	Doctor, hospital or other institution and address

I understand that the coverage I am applying for may be rescinded due to non-disclosure of medical history. _____ (client initials)

Important Notice on Exchange of Information

All information requested will be for insurance purposes only and will be treated as confidential. The Insurer or its reinsurers may, however make a brief report on it to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, the bureau will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, the bureau will arrange for disclosure to you of any information it may have in your file on you. If you question the accuracy of the bureau's file, you may contact the bureau and seek a correction. The address of the bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7 (Telephone (416) 597-0590).

Important Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial 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 products and services is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below. Your file is secured in our offices or the office of the administrator. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 2 Queen St. E., P.O. Box 4213 Stn A, Toronto, Ontario M5W 5M3.

Temporary Insurance Agreement

Manulife Financial, (the Company) agrees to provide Temporary Insurance coverage as applied for, provided the initial premium or credit card billing has been honoured by the financial institution and the questions in Section (E) are answered "NO", (reference # 1, 2a), 2b), or 3), subject to the following:

1. The terms, conditions, limitations, and exclusions, and other provisions of the policy applied for, will govern.
2. This agreement **DOES NOT** cover Sickness Disability or Sickness Disability Extension.
3. Temporary Insurance coverage ceases on the earliest of:
 - a) the date the policy applied for becomes effective; or
 - b) sixty (60) days from the date of the Payment Acknowledgement noted below; or
 - c) the date the Company sends notice to the proposed Primary Insured declining the application.

No representative of Manulife Financial is authorized to modify this agreement.

Payment Acknowledgement

The Company acknowledges payment of or authorization to bill the initial premium of \$ _____

Signature of Agent _____ Date _____