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| <input type="checkbox"/> Basic Life | <input type="checkbox"/> Term 100 | <input type="checkbox"/> Family Life |
| <input type="checkbox"/> Dental Office Staff Insurance | <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Office Overhead Expense |

Please complete and forward this form to CDSPI.

Name (print name in full)		Account No.
Date of birth (month)(day)(year)	Height _____ ft/in. or _____ m/cms	Weight _____ lbs. or _____ kilos

- Have you any reason to believe you are not in good health? Yes No
- Have you ever had or been treated for mental or nervous disorder (depression, anxiety, etc.), heart or circulatory trouble, chest pains, high blood pressure, diabetes, cancer, tumors, unusual infection or immune system abnormality, asthma, chronic cough or lung disorder, albumin in your urine or other illness or injury? Yes No
- Other than routine check-ups or minor ailments (colds, flu, etc.) have you had any medical or surgical advice or treatment or test, such as X-ray, electrocardiogram, blood chemistry, or taken medication for any ailment during the past 12 months? Yes No
- a) Have you ever used tobacco products? Yes No
 b) Date you stopped using tobacco products? _____
 (month) (day) (year)

If "YES" answered to any question above, give details below.

Question No.	Nature of Disorder	Duration & Date	Result	Attending Physician or Hospital

The statements contained herein are true and complete and together with other forms signed by me in connection with this application, form the basis for any certificate issued hereunder. I agree that any material misrepresentation, including misstatement of smoking status, shall render the insurance voidable at the instance of the insurer.

Relative to this application, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or of any member of my family insured under this plan, or of our health, to give to the Manufacturers Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Proposed Insured	Date Signed
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NOTICE ON PRIVACY AND CONFIDENTIALITY – TO BE DETACHED, READ AND RETAINED BY THE PERSON TO BE INSURED

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information:

- Manulife 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 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. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Consumer Markets, Manulife, P.O. Box 4213, Stn. A, Toronto, Ontario M5W 5M3, and
- Access to information which you provide to CDSPI or CDSPI Advisory Services Inc. or which CDSPI obtains in its capacity as the administrator of the group policy will be restricted to those employees, mandataries, administrators or agents of CDSPI or Professional Guide Line Inc. who are responsible for the marketing and administration of services and the facilitation of claims under the group policy, and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file at CDSPI or Professional Guide Line Inc. by writing to: Information Access Officer, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

NOTICE ON EXCHANGE OF INFORMATION – TO BE DETACHED, READ AND RETAINED BY THE PERSON TO BE INSURED

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).