

APPLICATION

For AdvantEdge and AdvantEdge Special Premium Rates for Basic Life or Family Life, or HealthEdge Rates for Long Term Disability, DisabilityGuard™ or Office Overhead Expense Insurance

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401 or 416.296.9401, Email: insurance@cdspi.com

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Please complete all pertinent questions to avoid processing delays and return to: **CDSPI**,
155 Lesmill Road, Toronto, Ontario M3B 2T8. Fax: 1.866.337.3389 or 416.296.8920

Accessible formats and communication supports are available upon request. Visit cdspi.com/accessibility for more information.

INDIVIDUAL INFORMATION

Section 1 Applicant Information

1. Name *(please print)*:
 Check one: Dr. Mr. Mrs. Miss Ms. Corporation

 Last *(or name of partnership or corporation)* First Middle or Middle Initial
2. Individuals only: Male Female
3. Mailing Address:
 Check one: Home Business

 Street and Number Suite No.

 City/Town Province Postal Code
4. _____
 Business Telephone Home Telephone

 Mobile Telephone Fax
5. _____
 Email address *(please include to expedite the application process)*
6. Account Number, if known:

Section 2 Person To Be Insured

Note: Please complete even if the Person To Be Insured is the same as the applicant.

1. Name *(please print)*:
 Check one: Dr. Mr. Mrs. Miss Ms.

 Last First Middle or Middle Initial
2. Male Female
3. Smoker Non-Smoker[†]
4. Date of Birth:
 D D M M Y Y Y Y
5. Country of Birth: _____
6. Plan(s) insured under:
 Basic Life Insurance
 Family Life Insurance
 DisabilityGuard™ Insurance
 Office Overhead Expense Insurance
 Long Term Disability Insurance

[†] **Note:** You are considered a non-smoker if you have not used any form of tobacco or tobacco cessation products in the last 12 months prior to signing this application. Note, however, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

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DECLARATION OF INSURABILITY

Section 3 Declaration of Insurability

For Quebec residents, please fill out this box only if detaching Section 3 (see note for Quebec residents at the end of Section 3):

Name of Person To Be Insured:

Date of Birth:

Date Applicant Signed:

Last

First

Middle or Middle Initial

To be completed by the person to be insured

YOUR PERSONAL INFORMATION

	YES	NO
<p>Have you:</p> <p>1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason: _____ _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>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: _____ _____</p> <p>b) Within the past 3 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: _____ _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. 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): _____ _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>4. Within the next 12 months:</p> <p>a) Any travel plans for travel outside of Canada and the United States of America? If yes, give details including where, when, why and for how long: _____</p> <p>b) Any expectation 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: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Within the past 5 years:</p> <p>a) Used any drugs for other than medical purposes, used marijuana, or been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug(s) used, alcohol type(s), daily consumption and date(s) last used: _____ _____</p> <p>b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details: _____ _____</p> <p>c) Declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge: _____ _____</p>	<input type="checkbox"/>	<input type="checkbox"/>

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Section 3 Declaration of Insurability (cont'd)

IMPORTANT: Any reference to testing, tests, test results or investigations in this section excludes genetic tests. Genetic tests 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 MEDICAL INFORMATION

Physician's name: _____

Physician's address and telephone number: _____

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

Height: _____ ft/in m/cm

Weight: _____ lb kg

Has your weight changed in the past year? Yes No

If yes: Gained _____ lb kg Lost _____ lb kg

Reason for change: _____

	YES	NO
<p>6. Have you ever had any indication of or been treated for conditions involving any of the following:</p>		
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
e) Your breast , such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
g) Your eyes or ears , such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	<input type="checkbox"/>	<input type="checkbox"/>
h) Your mental health , such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
k) Your skin , such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
m) Cancer, cysts, lumps, polyps, or tumour?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
<p>7. If female, a) are you currently pregnant?</p>		
If yes, give due date, and the name and address of your obstetrician/gynecologist: _____	<input type="checkbox"/>	<input type="checkbox"/>
b) What was your pre-pregnancy weight? _____ <input type="checkbox"/> lb _____ <input type="checkbox"/> kg		
c) Have there been any complications with your pregnancy? If yes, provide details: _____	<input type="checkbox"/>	<input type="checkbox"/>

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Section 3 Declaration of Insurability (cont'd)

	YES	NO
8. PLEASE SKIP QUESTION 8 IF ONLY APPLYING FOR LIFE INSURANCE.		
During the past 5 years, have you:		
a) Been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain, sciatica, or other?	<input type="checkbox"/>	<input type="checkbox"/>
b) Had X-rays (including of the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	<input type="checkbox"/>	<input type="checkbox"/>
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or checkups?	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the past 2 years, have you:		
a) Had an abnormal mammogram, PSA or any other test or investigation?	<input type="checkbox"/>	<input type="checkbox"/>
b) Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Been advised to undergo further investigation, see another doctor or have surgery?	<input type="checkbox"/>	<input type="checkbox"/>
d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the questions in the section titled **Your Medical Information**, please provide details in the table below. If more space is required, please attach a separate sheet (dated and signed):

YOUR MEDICAL INFORMATION DETAILS

Question Number & Part	Nature of Disorder	Date & Duration	Treatment (if None, state "None") & Current Status* Include the results of all physical examinations and checkups.	Attending Physician or Hospital

Note: If you need more space, please use a separate signed and dated sheet of paper, and attach to this form.

YOUR FAMILY MEDICAL HISTORY

	YES	NO
10. Have any of your parents or siblings (brothers or sisters):		
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
b) 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?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to question a) or b) above, please complete the following:

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

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Section 3 Declaration of Insurability (cont'd)

Quebec residents only: When your completed application is returned to CDSPI, Section 3 will be detached and sent to Manulife and no file copy will be retained at CDSPI's offices. However, you also have the choice of detaching Section 3 of this application and submitting it directly to Manulife. If you wish, you may complete the entire application and mail Section 3 only to the following address: ATTN: Consumer Markets Program Underwriting Department, Manulife, P.O. Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8. All other sections of the completed application must be mailed to: CDSPI, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

If you are detaching Section 3 and mailing it directly to Manulife, please complete the name of the Person To Be Insured, their date of birth and the CDA membership number of the applicant listed in Section 1.

This application will not be considered complete unless a properly completed, signed and dated Declaration of Insurability is received by Manulife.

Name of Person To Be Insured:	CDA Membership Number (Applicant):	Date of Birth (Person To Be Insured):	Date Applicant Signed:
_____	_____	_____	_____
Last	First	Middle or Middle Initial	
		D D M M Y Y Y Y	D D M M Y Y Y Y

DECLARATION AND AUTHORIZATION

Section 4 To Be Read, Signed and Dated By the Applicant (and Person To Be Insured if other than the Applicant)

If this application is approved, the applicant will receive a certificate booklet containing a detailed description of coverage, conditions, limitations and exclusions.

I apply to The Manufacturers Life Insurance Company (Manulife) for consideration for AdvantEdge and/or AdvantEdge Special premium rates, or HealthEdge and/or HealthEdge Special premium rates, for the insurance indicated above under the group policy and/or Master Agreement in connection with CDSPI.

I/We, the undersigned, declare that the statements contained in this application, including the statements in the Declaration of Insurability, are true and complete, and together with any other forms or documents signed or provided by me/us in connection with this application, form the basis for any Certificate of Insurance issued. I/We understand that any material misrepresentation at the time of application, including misstatement of smoker status, shall render any insurance issued pursuant to this application voidable at the instance of the insured. Suicide within two (2) years of the effective date or reinstatement date is a risk not covered. I/We understand that the insurance will take effect on the date the properly completed application is approved by Manulife, subject to the Person To Be Insured being actively at work on that date and the receipt of payment of the first premium within 30 days of issuance of a premium invoice. I/We understand that any health information must be accurate as of the date the application is signed. I/We understand that Manulife may request a medical examination, urinalysis or tests such as a general blood profile, including blood test for HIV, which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department, if required by law. I/We acknowledge receipt of and confirm my/our agreement with the Notice on Privacy and Confidentiality and the Notice on Exchange of Information. Relative to the insurance applied for, I, the Person To Be Insured, authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB Group, Inc., the group policy administrator, the insurance plan sponsor, any investigative and security agency, any credit bureau or credit reporting agency, any agent, broker or market intermediary, any government agency or other organization or person (including my accountant) that has any records or knowledge of me, my health or my finances to provide to Manulife or its reinsurers any such information for the purposes of this application and contract and any subsequent claim. I/We authorize Manulife to consult its existing files for this purpose. I/We authorize Manulife to obtain a credit report and/or a consumer report. 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. I/We understand that 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. A photocopy or facsimile of this authorization shall be as valid as the original.

_____	Date: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>									D	D	M	M	Y	Y	Y	Y	Signed at: _____
D	D	M	M	Y	Y	Y	Y											
Signature of Person To Be Insured (if other than the Applicant)		City/Town _____	Province/Territory _____															
_____	Date: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>									D	D	M	M	Y	Y	Y	Y	Signed at: _____
D	D	M	M	Y	Y	Y	Y											
Signature of Applicant		City/Town _____	Province/Territory _____															

QUEBEC RESIDENTS ONLY: If you have chosen to send Section 3 directly to Manulife, please indicate the date you sent Section 3 to Manulife:

Date:

D	D	M	M	Y	Y	Y	Y

NOTICE ON PRIVACY AND CONFIDENTIALITY – Must be detached, read and retained by the person 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. These people, organizations and service providers may be in jurisdictions outside of Canada, and subject to the laws of those foreign jurisdictions. 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, Ontario N2J 4C6.

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 Master Agreement and/or group policy will be restricted to those employees, mandataries, administrators or agents of CDSPI or CDSPI Advisory Services Inc. who are responsible for the marketing and administration of services and the facilitation of claims under the Master Agreement and/or 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 CDSPI Advisory Services Inc. by writing to: The Chief Privacy Officer, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

Plan Underwritten by The Manufacturers Life Insurance Company



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NOTICE ON EXCHANGE OF INFORMATION – Must be detached, read and retained by the person insured

Information regarding your insurability will be treated as confidential. Manulife 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. Manulife 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. 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, Ontario M5G 1R7. Information for consumers about MIB may be obtained on its web site at www.mib.com.

Plan Underwritten by The Manufacturers Life Insurance Company