

Term Life Application Form

PLEASE PRINT (Complete this section even if only your spouse is applying for coverage.)

First Name(s)				Last Name			
Address							Apartment/Unit No.
City/Town		Province/Territory		Postal Code		Telephone Number	
Date of Birth		Gender		Area Code			
Day Month Year		<input type="checkbox"/> Male <input type="checkbox"/> Female		E-mail Address*			
Name of Group or Association :							

*Each time you receive an e-mail from us, you will have the option to opt out of our mailing list.

Spouse Information (to be completed only if spouse is applying for coverage)

First Name(s)				Last Name			
Date of Birth							Gender
Day Month Year							<input type="checkbox"/> Male <input type="checkbox"/> Female

PLEASE INDICATE THE AMOUNT OF TERM LIFE INSURANCE YOU WISH TO PURCHASE:

Member:	<input type="checkbox"/> \$25,000	<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
Spouse:	<input type="checkbox"/> \$25,000	<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

BENEFICIARY DESIGNATIONS

Life Insurance

Under Member's Policy

First Name	Last Name	Relationship to Member
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In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary

If you have named a beneficiary under age 18, please indicate the name of the Trustee. Insurance benefits cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. To ensure underage beneficiaries are protected, please ensure that a legal guardian or trustee has been appointed through your Will.

Trustee: _____

First Name	Last Name
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Under Spouse's Policy

First Name	Last Name	Relationship to Spouse
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In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary

If you have named a beneficiary under age 18, please indicate the name of the Trustee. Insurance benefits cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. To ensure underage beneficiaries are protected, please ensure that a legal guardian or trustee has been appointed through your Will.

Trustee: _____

First Name	Last Name
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If a beneficiary is not provided, proceeds will be paid to your estate.

TERMS AND CONDITIONS - Please read carefully before signing.

Declaration

Is the policy applied for intended to replace any existing insurance? Yes No If "yes", list policy number(s) to be replaced and insurer(s).

Member's policy # _____ Spouse's policy # _____

(The insurer may decline an application which indicates replacement is intended. A new policy is not considered to be a replacement if the existing coverage will end automatically because of age limit, retirement, or some other event that is not of the applicant's choice.)

I/we hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/we, the undersigned, declare that the statements contained in this application are true and complete. I/we understand that the application together with any other forms signed by me/us in connection with this application form the basis for any policy issued hereunder. 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 is a risk not covered. I/we understand that insurance will take effect on the date my/our properly completed application and the first premium are received by Johnson Inc., subject to the approval of the insurer's underwriters.

Authorization and Revocation

Relative to the insurance applied for, I/we, the undersigned applicant(s), 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, the third-party administrator of this program, Johnson Inc., any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me/us or my/our health or the health of any person to be insured under this plan to provide to 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 the information in this application and its existing files to offer me/us their products or services. I/we understand that my/our consent to the use of such information to offer me/us products or services is optional and that if I/we wish to discontinue such use I/we may write to Manulife Financial at the address shown on this document. A photocopy or facsimile of this authorization shall be as valid as the original.

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/we hereby designate the individual(s) named as beneficiary to receive the proceeds payable on my/our death.

I acknowledge receipt of the Notice on Exchange of Information and the Notice on Privacy and Confidentiality (see brochure).

A sample cheque marked "VOID" is enclosed. Johnson Inc., the plan administrator, is authorized to make monthly deductions from the bank, trust company or credit union accounts shown on the cheque (the initial deduction may cover up to 3 months of premiums) for monthly premiums due on or after the date of this application.

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	Date
Spouse's Signature (if applying)	Date

MEDICAL QUESTIONS - MUST BE COMPLETED BY EACH PERSON APPLYING FOR TERM LIFE COVERAGE.

Member's Full Name	Telephone Number	Date
Member's Physician Name	Telephone Number	
Date last seen (D/M/Y)	Give Reason	Give Result
Spouse's Physician Name	Telephone #	
Date last seen (D/M/Y)	Give Reason	Give Result
Member's Height	Weight	Spouse's Height Weight

	Member		Spouse	
	Yes	No	Yes	No
1. Have you ever had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), heart or circulatory disorder, chest pains, high blood pressure, diabetes, cancer, tumours, lung or liver disorders, hepatitis (including carrier state), unusual infection or immune system abnormality, HIV, AIDS, kidney disorders, urinary abnormality, drug or alcohol consumption or other illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 2 years, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flus, etc.), been advised to see another doctor or to have surgery or had an abnormal investigation or test result?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever applied for insurance that was declined, modified or rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Smoked cigarettes or marijuana in the last 12 months? (If other forms of tobacco used, give details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. During the past 3 years have you ever had your driver's licence suspended? If yes, state reason, date and provide licence number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Member: _____ Spouse: _____				

If you answered "yes" to any of the questions above, please provide details below. If you require additional space, please use a separate page.

Ques. #	Name	Nature of disorder	Duration and date	Result	Attending physician or hospital

NOTE: The Insurer may request a medical examination, urinalysis or tests such as 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 health department if required by law.