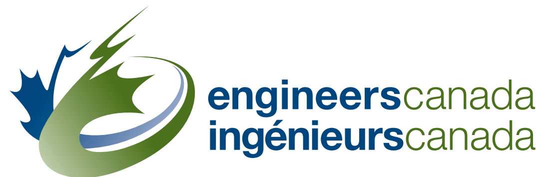
Application

for the

Member's Plan

Sponsored by



Recommended by

Administered by

Underwritten by
The Manufacturers Life Insurance Company

Manulife Financial
For your future™

Application for the Member's Plan
Engineers Canada

Group Number 578

SECTION 1 – MEMBER INFORMATION (PLEASE PRINT.)

First Name and Middle Initial | Last Name (include maiden name (in brackets), if applicable)

☐ Male
☐ Female

Address – Street/Apt. No. | City/Town | Province/Territory | Postal Code

Send Mail to:
☐ Residence
☐ Business

Date of Birth (dd/mm/yy) | Place of Birth (City/Country) | ( ) Residence Telephone Number | ( ) Business Telephone Number

E-mail Address

Certificate Language:
☐ English
☐ French

Employer Name | Street/P.O.Box

City/Town | Province/Territory | Postal Code

*To be eligible for this insurance you must be a member of the Ordre des ingénieurs du Québec or a full-time employee of the Ordre des ingénieurs du Québec **and** a resident of Canada, under age 65.*

For the purposes of this application, both a member and an employee shall be considered a "Member".

Ordre des ingénieurs de Québec Membership Number ____

Who will own this coverage? ☐ Member ☐ Other Party (if other party, complete Owner sections)

Owner Name | Relationship to Member

Owner Address, including Postal Code | Owner Membership Number (if applicable)

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Section 2 – Selecting your coverages

The Effective Date of all selected coverages will be the first of the month following the date of approval, unless otherwise noted.

2.1 **Disability Income Replacement Coverage**

Coverage minimum:
$500
Coverage maximum:
$10,000

Benefit Period:
Lifetime Accident and
To age 70 Illness

Elimination Periods Available:

0/7 days
14/14 days
30/30 days
90/90 days
119/119 days
180/180 days
365/365 days

If you are covered by Employment Insurance, select an Elimination Period of 90 days or longer.

	Coverage Required		Taxable	Premium Amount
a) Monthly Benefit	$ ______________		☐ Yes ☐ No	$ ____________
Elimination Period	______________	Days		
☐ Retroactive Benefit Rider				
b) Monthly Benefit	$ ______________		☐ Yes ☐ No	$ ____________
Elimination Period	______________	Days		
☐ Retroactive Benefit Rider				
c) Monthly Benefit	$ ______________		☐ Yes ☐ No	$ ____________
Elimination Period	______________	Days		
☐ Retroactive Benefit Rider				
d) Monthly Benefit	$ ______________		☐ Yes ☐ No	$ ____________
Elimination Period	______________	Days		
☐ Retroactive Benefit Rider				

Note: If you are paying your disability premiums yourself, then any benefit payments you receive will be non-taxable. If your employer is paying any part of the premium, then any benefit payments you receive will be taxable.

2.2 **Business Overhead Expense Coverage**

Benefit Period:
12 months

Elimination Periods Available:

14/14 days
30/30 days

	Coverage Required		Premium Amount
Total Reimbursement Benefit	$ ______________		$ ____________
Elimination Period	______________	Days	

Note: Available in units of $100/month to a maximum of $8,000/month for any one accident or illness.

2.3 Indicate the name(s) of your Designated Beneficiary(ies) in full below. *NOTE:* Spousal beneficiary designation in Quebec is irrevocable unless you specifically write "revocable" below.

Name	**Relationship**	**Coverage to which the designation applies**

If the beneficiary is under age 18, please provide the name of a Trustee. (not applicable to residents of Quebec)
I (the Owner) understand that unless indicated otherwise I am automatically the Beneficiary for any death benefit provided under the plan(s).
If more than one Beneficiary is named, the proceeds shall be paid to the surviving Beneficiary(ies).
If the Beneficiary(ies) named above does(do) not survive me, any proceeds will be payable to my estate.

SECTION 3 – EXISTING COVERAGE

3.1 Do you have any pending or in-force coverage with Manulife Financial or any other company, including life, critical illness, disability insurance or business overhead expense? ☐ Yes ☐ No

Company	Issue date (mth/yr)	Type of insurance	Amount	Elim. period	Benefit period	Taxable benefit	Is Insurance being replaced?
________	________	________	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No
________	________	________	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No
________	________	________	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No
________	________	________	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

3.2 Are you eligible for Employment Insurance? . . . . ☐ Yes ☐ No

3.3 Are you eligible for compensation from Workers' Compensation? . . . . ☐ Yes ☐ No

3.4 Have you ever had a new or reinstatement application for health care, life, disability, or critical illness insurance rated, modified, declined, postponed, withdrawn or rescinded? . . . . ☐ Yes ☐ No

If yes, provide details. ____

SECTION 4 – HEALTH DECLARATION

Complete all questions below. Provide full details below or attach a separate sheet (signed and dated).

Member

4.1 Name and address of personal Physician or Doctor last consulted

____

____

____

4.2 Date of last consultation

____

4.3 Reason for last consultation

____

____

____

4.4 Test, Treatment, Medication prescribed (If none, state "None")

____

____

____

4.5 Results and current status

____

____

Member

4.6 Height ________ ☐ ft/in ☐ cm

Weight ________ ☐ lbs ☐ kg

4.7 In the past year, weight has:

☐ Remained same

☐ Increased

☐ Decreased

Reason for change: ______________________

Complete all questions below. Provide full details below or attach a separate sheet (signed and dated).

		YES	NO
4.8	Are you now under medical observation or receiving any type of medical treatment?	☐	☐
4.9	Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	☐	☐
4.10	Within the past 5 years:		
	a) have you 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 check-ups?	☐	☐
	b) have you had an electrocardiogram (ECG), blood tests, X-rays or other diagnostic tests?	☐	☐
	c) have you been under observation or treatment in any hospital, clinic, sanatorium or other institution or facility?	☐	☐
	d) have you been advised to have any diagnostic test, consultation, hospitalization or surgery, which has not been completed?	☐	☐
4.11	Have you ever had any indication of, or been treated for, a disorder of:		
	a) the ears, eyes, nose, throat or lungs—including tinnitus, blurred vision, shortness of breath, bronchitis, pleurisy, asthma, pneumonia, emphysema, tuberculosis, sleep apnea or chronic respiratory disorder?	☐	☐
	b) the nervous system—including migraine, headaches, seizures, dizziness, fainting, paralysis, numbness, tingling, coma, multiple sclerosis, motor neuron disease (ALS), or loss of speech?	☐	☐
	c) the heart or blood vessels—including chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, abnormal ECG, elevated cholesterol, angina, cerebrovascular disease (CVA), transient ischemic attack (TIA), dizziness, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	☐	☐
	d) the abdominal organs—including ulcer, hernia, colitis, gallstones, jaundice, hepatitis (including hepatitis B carrier), Crohn's disease or other disorder of the stomach, liver, pancreas or intestines?	☐	☐
	e) the kidneys, bladder, genitals—including sugar, blood, pus or albumin in the urine, stones, venereal disease or any other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
	f) the blood, glands or lymph glands—including diabetes, anemia, gout, allergies, skin disorders, lesions, lupus, thyroid, unusual bleeding or other endocrine disorders?	☐	☐
	g) rheumatic fever, rheumatism, arthritis, neuritis, fibromyalgia, spinal disorder, chronic pain, or any other disease or disorder of the bones, joints or muscles?	☐	☐
	h) the spine, back, neck—including sprain, strain, pain or disc disease? If yes, please complete a Back Pain Questionnaire.	☐	☐
	i) cysts, polyps, tumours or cancer?	☐	☐
	j) the breast—including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy?	☐	☐
4.12	Have you ever:		
	a) had, or been advised to have, treatment or counselling for anxiety, stress, "burnout", depression, fatigue, chronic fatigue or any emotional, behavioural, mental or nervous disorder?	☐	☐
	b) attempted suicide?	☐	☐
4.13	Have you been absent from work for more than a two-week period due to disability within the last two years?	☐	☐
4.14	Have you ever been tested (other than for insurance), treated, counselled for or diagnosed with:		
	a) Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other immunological disorders?	☐	☐
	b) enlargement of the lymph nodes (glands), chronic diarrhea, unusual skin lesions or unexplained infections?	☐	☐
4.15	Within the past five years have you had any mental or physical disorder not listed above?	☐	☐
4.16	Are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐
4.17	Have you ever received or claimed benefits or a pension for any sickness, injury or impairment?	☐	☐
4.18	Have you:		
	a) within the past twelve months, used any products containing nicotine (including but not limited to, cigarettes, cigars, pipes, smokeless tobacco, nicotine gum, the nicotine patch or other smoking cessation products)?	☐	☐
	b) ever been advised to quit smoking for health reasons?	☐	☐

Complete all questions below. Provide full details below or attach a separate sheet (signed and dated).

		YES	NO
4.19	Do you drink alcoholic beverages? If yes, complete table below. (One drink means a 12 oz. bottle of beer, 4 oz. glass of wine or $1^1/_2$ ounces of spirits)	☐	☐

Member

Type	Number of Drinks	Frequency
Beer		
Wine		
Liquor		

		YES	NO
4.20	Have you ever been advised to decrease alcohol consumption?	☐	☐
4.21	Have you:		
	a) ever consulted a doctor or received treatment due to the use of alcohol and/or drugs?	☐	☐
	b) used drugs other than basic prescription drugs and/or over-the-counter drugs? This includes but is not limited to marijuana, cocaine or other narcotics as well as sedatives, hallucinogens, hypnotics, tranquillizers or stimulants. If Yes, complete a Drug Usage Questionnaire.	☐	☐
4.22	This question is to be completed by all female applicants:		
	a) Are you currently pregnant? If yes, give due date: ____________ (mm/yy)	☐	☐
	b) Have you ever had a miscarriage, pre-eclampsia, caesarean section or other complication of pregnancy?	☐	☐
4.23	Did your natural father or mother or any of your brothers or sisters ever have diabetes, high blood pressure, heart disease, kidney disease, cancer, stroke, multiple sclerosis, motor neuron disease (ALS), nervous or mental disorders or any hereditary disorder? If yes, indicate relationship, disease, age at onset and, if applicable, age at death. If cancer, please specify type: _____________	☐	☐

For every “yes” answer given in questions 4.8 through 4.23, please provide full details. If more space is required, attach a separate sheet (signed and dated).

Question number	Reason for consultation	Date of first visit/treatment	Date of last visit/treatment	Current status	Name/address of Physicians/Hospitals

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 provincial or territorial health department, if required by law.

Section 5 – Non-medical information

Complete all questions below. Provide full details below or attach a separate sheet (signed and dated).

		YES	NO
5.1	Have you ever been: a) charged with impaired driving, had your driver's licence suspended, or been convicted of a traffic violation or criminal offence relating to the use of alcohol while driving? If yes, give details, including driver's licence number and licensing province: ______________________	☐	☐
	b) convicted of any other criminal offence?	☐	☐
5.2	Have you ever piloted a plane, ultra-light or glider, or do you intend to do so?	☐	☐
5.3	Have you ever participated in scuba diving, parachuting, hang gliding, ultra-light flying, motor vehicle or motorboat racing, rodeo activities, mountain-climbing or any other hazardous sport (including extreme sports) or avocation, or do you intend to do so?	☐	☐
5.4	Within the next 12 months, have you any intention of travelling or residing outside North America other than for vacations? If yes, provide details including where, when, why and for how long.	☐	☐

Question number	Details

Section 6 – Financial/Employment information

6.1 What is/are your:
a) occupation(s) ______________________
b) professional designation(s) or degree(s) ______________________
c) Occupational duties: (give description of duties and % of time spent performing each)
____

6.2 How many years have you worked in this occupation? ______________
If less than 2 years, also give former occupation details. ______________________

6.3 With respect to your employment/financial situation:
a) How many hours a week do you work? ______________
b) What % of this time is spent working in your home? ______________ %
c) Do you expect your income or employment situation to differ from the past 2 years? ☐ Yes ☐ No
If yes, provide details. ______________________

6.4 Is your employment seasonal? ☐ Yes ☐ No
If yes, indicate the number of weeks worked per year. ______________

6.5 Do you have any part-time or other full-time jobs? ☐ Yes ☐ No
If yes, provide details. ______________________

6.6 Indicate your employment status: ☐ Employee (no ownership) ☐ Self-employed

6.7 If self-employed, what is the organization of your business and your percentage of ownership?
☐ sole proprietor ☐ partnership ______ (% ownership) ☐ corporation ______ (% ownership)

6.8 a) Number of years in current business ______________
b) Number of years in a similar business ______________

6.9 What is your net annual income after regular business expenses but before taxes as declared to Canada Revenue Agency?
Current year expected $ __________ prior year $ __________ 2 years prior $ __________

6.10 Any other earned income? ☐ Yes ☐ No
If yes, indicate source: ______________________
Current year expected $ __________ prior year $ __________ 2 years prior $ __________

Proof of Income

Employee: Pages 1, 2 and 3 of past 2 years' tax returns.

Self-employed—Unincorporated: Pages 1, 2 and 3 of past 2 years' tax returns plus Statement of Professional or Business Activity.

Self-employed—Incorporated: Pages 1, 2 and 3 of past 2 years' tax returns plus latest Corporate Financial Statement.

If income splitting for tax purposes: Family member's T4 from the business for past 2 years.

6.11 Have you ever had a licence or permit which was required to operate a business suspended or revoked or has a regulating agency ever initiated a complaint against you? . . . . ☐ Yes ☐ No

6.12 Have you ever declared or are you contemplating personal or business bankruptcy? . . . . ☐ Yes ☐ No
If yes, provide details including date of discharge below.

6.13 Does your net worth (assets minus liabilities) exceed $4,000,000? . . . . ☐ Yes ☐ No
If yes, provide breakdown below.

6.14 Does your unearned income (income that will continue during a disability, for example, investment income, net rental income, royalties, or similar income) exceed 15% of your total earned income? ☐ Yes ☐ No
If yes, provide amount and sources below.

Provide details to 'Yes' answers to questions 6.11 to 6.14 here.

____

____

____

____

Section 7 – Business Overhead Expenses

7.1 How many persons share the expenses? ____________ What is your proportion? ____________%

7.2 Number of employees: ________ State position held by each: a. ____________ b. ____________
c. ____________ d. ____________ e. ____________ f. ____________

7.3 List the average monthly expenses incurred in the operation of the office:

Expenses	Your share
a) Rent or property taxes and mortgage interest payments (applicable to business only)	____________
b) Office maintenance	____________
c) Public utilities (heat, water, electricity)	____________
d) Telephone, postage, paging, fax and answering service	____________
e) Employee salaries and benefits (except as below)	____________
f) Management company fees (excluding family-owned firm)	____________
g) Accounting services	____________
h) Professional association membership fees	____________
i) Property and liability insurance premiums	____________
(I) Leased equipment or	____________
(II) Scheduled principal payments, interest payments plus depreciation for equipment	____________
j) Interest plus principal payments for business loans to purchase business from a financial institution	____________
k) Itemize other fixed monthly expenses (normal and customary):	
(I) ____________	____________
(II) ____________	____________
Total	____________

Do not include expenses incurred for:

- the purpose of acquiring goods for sale, supplies or additions to inventory;
- salaries, fees, drawing account or remuneration for: the Member, any member of the Member's profession or related profession, or any person sharing the business expenses of the Member;
- travel and/or entertainment.

SECTION 8 – PREMIUM PAYMENT MODE:

☐ **PAYMENT BY CHEQUE**

☐ Annual ☐ Semi-Annual

☐ **PAYMENT BY PRE-AUTHORIZED DEBIT (PAD) - MONTHLY ONLY.**

Please enclose a cheque marked "VOID".

FOR PRE-AUTHORIZED DEBIT (PAD) PAYMENT

Name of Account Holder ____

Financial Institution ________________________ Address __________________________________ City/Town _______________

Bank Account Number ____________________________________ Transit Number ______________________________________

Type of Service: ☐ Personal ☐ Business

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.

I/We authorize the distributor Sogemec Assurances inc. to make Pre-Authorized Cheque Withdrawals from my bank account for the purpose of paying premiums as they fall due. If premiums change for the policy issued for this Application, I authorize Sogemec Assurances inc. to amend the amount of pre-authorized cheque withdrawals. This payment method may be cancelled by providing 10 days written notice to Sogemec Assurances inc. or to the financial institution indicated on the Application for Insurance. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. **I/We waive the right to receive 10 days' 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 withdrawal the first time it is presented for payment, Sogemec Assurances inc. may attempt to withdraw that payment again within 30 days. Sogemec Assurances inc. 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 the Canadian Payments Association in Rule H-1. I/We and/or Sogemec Assurances inc. 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 Sogemec Assurances inc. 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.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1 800 361-5303, information@sogemec.qc.ca or write to us at Sogemec Assurances inc., 2, Complexe Desjardins, East Tower, 20th Floor, P.O. Box 217, Desjardins Station, Montreal, Quebec H5B 1G9.

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.cdnpay.ca.

Name of Account Holder __________________________________ Signature of Account Holder___________________________

Second Signature If Joint Account ___________________________________ Dated ________________________ (dd/mm/yyyy)

Account Holder Address (if different from Applicant) ____

Sogemec Assurances inc. is a contracted representative of The Manufacturers Life Insurance Company.

Note: Residents of Ontario add 8% Provincial Sales Tax. Residents of Quebec add 9% Provincial Sales Tax.

SECTION 9 – SALES REPRESENTATIVE/AGENT INFORMATION

Amount submitted with Application $ ______________________________ Checked by: ______________________________

Name of Sales Representative/Agent: ______________________________ Agent Number: ______________________________

Underwriting Requirements Ordered: ☐ Urine HIV ☐ Paramedical ☐ Medical ☐ Blood Profile ☐ E.C.G. ☐ Inspection Report
☐ Other ______________________________

______________________________	______________________________	______________________________
Name of Paramedical Facility/Examiner	Name of Inspection Company	Special Instructions

SECTION 10 – AGREEMENTS & AUTHORIZATIONS

All proposed insureds must read this section, and sign and date it.

1. I am a Member or full-time employee of the Provincial/ Territorial Constituent Association named in the application and have met the eligibility conditions for insurance coverage according to the master policy.
2. Any experience credits that may accrue under the master policy by virtue of which this application is made shall accrue to the master policyholder.
3. I hereby authorize The Manufacturers Life Insurance Company to transfer all records in their possession to any new insurer Engineers Canada may appoint in the future.
4. I hereby apply for insurance or (if applicable) consent to insurance being placed on my health, to The Manufacturers Life Insurance Company (Manulife Financial).
5. I declare that the statements contained in this application, including the Health Declaration originally attached hereto, are true and complete. I understand that this application, together with any other forms signed by me in connection with this application, form the basis for any certificate issued hereunder.
6. The person to be insured understands that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I understand that exclusions and limitations apply to the coverage applied for. Relative to the insurance applied for, I, the person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB, the group policy administrator, the insurance plan sponsor, 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 or my health 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 authorize Manulife Financial to consult its existing files for this purpose.
7. I authorize Manulife Financial, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me their products or services. I understand that my consent to the use of such information to offer me products or services is optional, and that if I wish to discontinue such use, I may write to Manulife Financial at the address shown on this document.
8. A photocopy or faxed copy of this authorization shall be as valid as the original.
9. I acknowledge receipt of, and confirm my agreement with, the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.
10. I declare that I 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 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.
11. I understand that subject to the Company's receipt of the properly completed application form (including my properly completed Health Declaration), and the first premium payment, coverage will take effect on the first of the month following approval of the Company's underwriters. I understand that any health information must be accurate as at the date the application is signed. If I am approved, I will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am not insurable, a full refund of the premiums will be made.

QUEBEC RESIDENTS ONLY:

☐ I have expressly requested that this Agreement and any related appendices or documents be drafted in the English language. J'ai expressément demandé que la présente entente et les annexes ou documents y afférents soient rédigés en anglais.

Signed in the City of ______________________________ and Province of ______________________________

Signature of Member ______________________________ Date ____________ (dd/mm/yy)

Signature of Agent/Witness ______________________________ Date ____________ (dd/mm/yy)

Signature of Owner (if other than Member) ______________________________ Date ____________ (dd/mm/yy)

Hospitals and doctors may require an original authorization to release information. Please sign and date the authorization below to avoid any delays in our request for the necessary medical reports.

AUTHORIZATION TO OBTAIN INFORMATION: I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, program administrator, the MIB, consumer reporting agency, or other organization, institution or person which has records of my health to release such information to The Manufacturers Life Insurance Company or its reinsurers for the purpose of this application and contract and any subsequent claim.

Signature of Member ____ Date ____________________ (dd/mm/yy)

Hospitals and doctors may require an original authorization to release information. Please sign and date the authorization below to avoid any delays in our request for the necessary medical reports.

AUTHORIZATION TO OBTAIN INFORMATION: I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, program administrator, the MIB, consumer reporting agency, or other organization, institution or person which has records of my health to release such information to The Manufacturers Life Insurance Company or its reinsurers for the purpose of this application and contract and any subsequent claim.

Signature of Member ____ Date ____________________ (dd/mm/yy)

Hospitals and doctors may require an original authorization to release information. Please sign and date the authorization below to avoid any delays in our request for the necessary medical reports.

AUTHORIZATION TO OBTAIN INFORMATION: I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, program administrator, the MIB, consumer reporting agency, or other organization, institution or person which has records of my health to release such information to The Manufacturers Life Insurance Company or its reinsurers for the purpose of this application and contract and any subsequent claim.

Signature of Member ____ Date ____________________ (dd/mm/yy)

Section 12 – Temporary Insurance Receipt (Disability/Business Overhead Insurance)

It is acknowledged that the sum of $ ____________________ (an amount equal to at least one monthly premium) has been paid to Sogemec Assurances inc. POST-DATED CHEQUES ARE NOT ACCEPTABLE.

Amount of Disability Insurance Coverage $ ____________________

____
Name of Proposed Insured

____________________ ____________________
Signed in the City of and Province of

____________________ ____________________
Signature of Agent/Witness Date (dd/mm/yy)

Temporary Disability Insurance Agreement
No agent of The Manufacturers Life Insurance Company is authorized to modify this Agreement.

Effective date:
Temporary Insurance under this Agreement is effective when the application has been fully completed and signed and an amount equal to at least one monthly premium has been paid. The Proposed Insured must be eligible under The Manufacturers Life Insurance Company's current rules and practices for the coverage(s) applied for and if not, for the reduced or modified coverage the Proposed Insured is determined to be eligible for on the effective date of this Agreement.

Amount and Type of Temporary Insurance:
The maximum amount of insurance on the Proposed Insured under this and any other Temporary Insurance Agreement with The Manufacturers Life Insurance Company is limited to the amount of $5,000 per month.

Special Limitations:
There is no coverage under this Agreement if:

1. The age of the Proposed Insured is 55 or over as of their last birthday.
2. Any of the following questions on the application form are answered "Yes" or left blank: 3.4; 4.8; 4.9; 4.10 d); 4.11 b), c), f), h), i); 4.12 a), b); 4.14 a), b); 4.16, and 5.4.
3. There is fraud, misrepresentation or non-disclosure in this Agreement, our Application forms or the initial underwriting requirements.
4. Disability of the Proposed Insured is a result of self-inflicted injury.

Conditions for Termination:
Termination Date is the 90th day after the date this Application is signed.

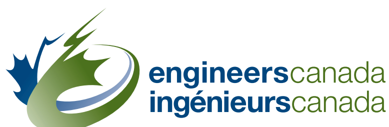
1. This Agreement terminates automatically when the coverage(s) applied for becomes effective or 90 days after the date of the Application. No written notice will be given for such termination.
2. The Manufacturers Life Insurance Company may terminate this Agreement at any time by giving notice to the Owner with a refund of any money paid, mailed to the Owner at the address for premium notices designated on this Application form. The termination date is the day following the mailing of the notice by The Manufacturers Life Insurance Company.

Section 13 – Detach (with care) and retain for your records

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 MIB. The MIB 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, your spouse or your children being insured under this plan. 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).

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 and Sogemec Assurances 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 or Sogemec Assurances 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. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. BOX 4213, STN A, TORONTO, ON M5W 5M3 or Sogemec Assurances : 2, Complexe Desjardins , Tour de l'est – 20e étage, C.P. 217 – Succ Desjardins – Montréal QC H5B 1G9.

Sponsored by:



Underwritten by:

The Manufacturers Life Insurance Company

Distributed and administered by

Sogemec Assurances inc.
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