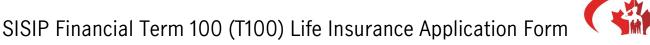
The Manufacturers Life Insurance Company



Please type or print in ink.

Part A — Applicant Information			
You are applying as a: CAF Member (Code: M)	Spouse of CAF Member (Code: S)	Child of CAF Member (0	Code: C)
CANADIAN ARMED FORCES (CAF) MEMBER S	ERVICE NUMBER:	Male	Female
L	'S/C	Smoker	Non-Smoker*
CAF Member Service Number (Please indicate if you are applying as a Member [M by entering the appropriate letter at the end of the		used any form of	es apply to people who have not of tobacco or tobacco cessation ling e-cigarettes, in the past 12
Applicant Name:			
Last	First		
Home Address:			
Street	Unit/Apt# City	Province	Postal Code
Date of Birth:	Place of Birth (province, country):		
Primary Phone Number:	Email:		
Occupation:			
Part B — Amount of Insurance A	pplied for (DO NOT include coverage	e already in force)	
APPLICANT COVERAGE AMOUNT Choose the amount of Term 100 Life Insurance of coverage amount is \$25,000. The coverage in-fit			00. The minimum
\$25,000 \$50,000 \$75,000			No
You must choose the Waiver of Premium Option a	at the time of Term 100 Life Insurance a	pplication. Please see brochu	ire for more information.
PREMIUM PAYMENT OPTIONS		FF	
Regular Premiums – pay to age 100	20 Pay Premium Option** – pay	for 20 years	
**20 Pay Option available to those 18 to 60 years of age.		•	
EXISTING COVERAGE Do you have any pending or existing life insuran	ce coverage with Manulife or any other	r company?	
Yes No If yes, complete the following:		A	
Company Name	Personal or Business	Coverage Amount	Do you intend to replace this coverage?
			Yes No
			Yes No
Note: If you intend to replace coverage, do not cancel you may be required, and we may not be able to issue a Financial term life insurance, no replacement form	n insurance contract where replacement is inc		
Part C – Beneficiary Information			
APPLICANT I hereby designate the individual(s) named as benefici If no beneficiary is designated, benefits will be payable		eath benefit payable with respec	t to the coverage applied for.
Beneficiary(ies):	to the Estate.		
1. Last Name First N	ameRelationship to Yo	ou, the Applicant	% of Benefit
2. Last Name First N			
Contingent Beneficiary(ies):			
1. Last Name First N	ameRelationship to Yo	ou, the Applicant	% of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

2. Last Name

Name (Last/First) _____

Relationship to the Beneficiary

_Relationship to You, the Applicant _

For Quebec residents only: In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed. Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

_ First Name _

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

_ % of Benefit

Part D – Personal Information

Have you:

Your Name

- 1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:
- 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:

b) Within the past 2 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:

- a) Within the past 5 years, used any drugs for other than medical purposes, used marijuana, or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug used, alcohol type(s), daily consumption and date(s) last used:
 - b) Within the past 5 years, been convicted of a criminal offence or are you currently charged with one? If yes, please provide details:

c) Within the past 5 years, declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge:

Outside of your military duties as a serving member:

- Have you 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):
- 5. a) Within the next 12 months do you expect to travel outside of Canada and the United States of America? If yes, give details including where, when, why and for how long:

b) Do you expect 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:

Part E – Your Health Declaration Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.) Quebec residents <u>may</u> detach this declaration page and send it directly to Manulife at the address shown on this application.

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

Telephone

Physician's Name Physician's Tele			an's Telephon	e					
Phy	sician's Address _	Number and	Street		Unit/Suite #	City		Province	Postal Code
Date	e, reason and res	ult of last cons	ultation, ar	nd treatment o	or medication	n prescribe	d, if any:		
Heig	ght	ft & in .	/ cm	Current	t Weight		lbs /	kg	
Has	your weight char	iged by more th	nan 10 lb (4	4.5 kg) in the	past year?	Yes	No		
lf ye		lbs /					for Change		
MED	DICAL INFORMATIO	N							
1. H	ave you ever had	l any indicatio	n of or be	en treated fo	r conditions	involving	any of the fo	llowing:	YES NO
a)		attack (TIA), ches	t pains or sh	nortness of brea	th, heart attack	-		vascular disease (CVA), s, high blood pressure,	stroke or
b)	Your nose, throat sarcoidosis, sleep a				ive pulmonary o	disease (CO	PD), chronic or	recurrent bronchitis, em	physema,
c)		rgans, such as:	cirrhosis, co	litis, Crohn's dis				ng, gastrointestinal reflu	x, hepatitis
d)	-	rder, protein in th	ne urine, urin	nary tract infection	on (UTI), sugar	or blood in	urine, uterine fi	stone, nephritis, prosta broids, polycystic kidney	
e)	Your breast, such	as: abnormal ma	mmogram fi	ndings or biopsy	y, cysts, lumps	or other phy	/sical changes,	or other?	
f)	Your brain or nerv fainting or syncope	-				imer's disea	se, multiple scl	erosis, numbness/tinglir	ıg,
g)	Your eyes or ears, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis,								

- g) Your eyes or ears, such as: blindness, blurred vision, deatness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?
- h) Your mental health, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?
 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?
 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?
- Your skin, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size or colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?
- I) 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?
- m) Cancer, cysts, lumps, polyps, or tumour?
- 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?

YES I NO

Part E – Your Health Declaration (continued)

2. Within the past 2 years, have you:

- a) Had an abnormal mammogram, PSA or any other test or investigation?
- Consulted a specialist, or been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)? b)
- c) Been advised to undergo further investigation, see another doctor or have surgery?
- Or are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness? d)

If you answered yes to any of the questions above in 1 or 2, please give details below. If additional space is needed, use a separate page, signed and dated:

Question Number	Nature of Disorder	Date and Duration	Treatment (if none, state "None") and Current Status	Attending Physician or Hospital

3. Your Family Medical History:

- Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer? a)
- Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease b)
 - (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?

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

Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause, if applicable
4. Female applicants only	·		YES NO

4. Female applicants only

- Are you currently pregnant? a)
- If yes, give due date and the name and address of your obstetrician/gynecologist:
- What was your pre-pregnancy weight? b) lbs /
- Have there been any complications with your pregnancy? If yes, provide details: C)

Part F – Your Payment Method (Please select Option #1 or Option #2)

OPTION #1: MONTHLY PRE-AUTHORIZED DEBIT - PAD Please enclose a sample cheque marked "VOID."

OPTION #2: ANNUAL PAYMENT BY CHEQUE Please enclose a cheque payable to Manulife Annual (please enclose a cheque payable to Manulife).

Manulife Bank 500 KING ST. NORTH WATERLOO, ONTARIO N2J 4C6		The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter in the following table.				
	<u>22</u> <u>540</u> .:	00011.001	<u>111</u> "			
Transit number Institution number Account number						

Part G – Payment Information and Authorization

PAYMENT INFORMATION | FOR PRE-AUTHORIZED DEBIT (PAD) PAYMENT OPTION

Name of Account	Holder		Financ	cial Institutio	n		
Address			City/T	own			
Bank Account Nur	nber		Branch	n Transit Nur	nber		
Type of Account:	Personal Chequing	Chequing/Savings	Savings	Current	Direct Deposit Account	Other	
Joint Accounts: Is	this a joint account req	uiring only one signature	e? Yes	s 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.

PAYMENT AUTHORIZATION | FOR PRE-AUTHORIZED DEBIT (PAD) PAYMENT OPTION

I/We authorize Manulife to withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date I/we sign this authorization. I/We authorize Manulife to withdraw premiums on or about the first business day of each month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and may change in accordance with my/our insurance contract and as required to administer my/our policy. I/We waive the right to receive further 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 monthly withdrawal the first time it is presented for payment, Manulife may attempt to withdraw that payment again within 30 days. Manulife 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 Payments Canada in Rule H1. I/We and/or Manulife 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 Manulife 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.payments.ca. If you have any questions about withdrawals from vour bank account, contact us at 1-855-887-7809, am service@manulife.com or write to us at Manulife. PO Box 670. Stn Waterloo, Waterloo, Ontario N2J 4B8.

YES I NO

YES NO

Part G – Payment Information and Authorization (continued)

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.payments.ca.

Name of Account Holder		Sig	gnature of Account Holder		
Second Signature If Joint Accoun	t			Dated	(DD/MM/YYYY)
Account Holder Address (if different from Applicant)	Number and Street	Unit/Suite #	City	Province	Postal Code

Information about MIB, Inc.

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, Inc. based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, Inc. is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, Inc. will share any information it has on file.

Personal Information Statement

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract, the insured providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to <u>www.manulife.ca</u>.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- Identifying information such as your name, address, telephone number(s), email address, date of birth or driver's licence
- A personal investigation, financial information, credit bureau report and/or a consumer report from any organization, person or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics and interests
- Other personal information we may require to administer our business relationship with you
- Medical information that any organization or person has about you
- Any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test
- Your personal information from MIB, Inc., as explained in Information about MIB, Inc.
- A copy of all driving-related information from provincial or territorial Motor Vehicle Divisions
- We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company
- Other sources, such as:
 - Your advisor or authorized representative(s)
 - Third parties with whom we deal in issuing and administering your policy now. and in the future
 - Public sources, such as government agencies and Internet sites

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- · Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the policy
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons, financial institutions and other parties with whom we deal in issuing and administering your policy now, and in the future
- Authorized employees, agents and representatives

You may review the information in your file, and request a correction if necessary, by contacting MIB, Inc. at:

MIB, Inc. 330 University Avenue, Suite 501 Toronto, Ontario M5G 1R7 Telephone: (416) 597-0590 Fax: (416) 597-1193 Email: canada_disclosure@mib.com

- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
 Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research,
- Your medical doctor
- Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:

- Will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- Will be shared with all the owners and any subsequent owners of those contracts and all people to be insured

How long do we keep your information?

The longer of:

- The time period required by law and by guidelines set for the financial services industry, and
- The time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the policy unless federal or provincial/territorial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care centre at 1-877-268-3763, or write to the Privacy Officer at the address below.

Accuracy and access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question or a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer Manulife P.O. Box 1602 500 King Street North Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

A copy of our privacy principles and practices is available at manulife.ca.

Declaration and Authorization - Please read carefully before signing.

I (the Applicant) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

I/We declare that the statements contained in this application, including the health declaration originally attached hereto, are true and complete. I/We understand that this application, together with any other forms signed by me/us in connection with this application, forms the basis for any certificate issued hereunder. The person(s) to be insured understand(s) that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer.

I/We understand that exclusions and limitations apply to the coverage applied for. Suicide within the first two years is a risk not covered. Relative to the insurance applied for, I/we, the person(s) to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB, Inc., 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/us or my/our health or the health of any member of my/our family to be insured pursuant to this application to provide to Manulife or its reinsurers any such information for the purpose 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 consumer report.

I/We authorize Manulife, 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 at the address shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/We acknowledge receipt of and confirm my/our agreement with the Information about MIB, Inc. and Personal Information Statement.

I (the Applicant) hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my or, if applicable, my Spouse's death.

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 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 acknowledge that the insurer 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 me/us. I/We further acknowledge that results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law and that, based on my/our health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

I/We acknowledge that coverage will take effect on the date the properly completed application (including my/our properly completed health declaration) and the first premium are received by Manulife, subject to the approval of the Company's underwriters. If I am/we are applying for new coverage and am/are approved, I/we will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am/we are not insurable, a full refund of the premiums will be made.

By providing your email address herein, you consent to us providing information or documents to you in respect of this application or policy, as applicable, in electronic form.

Signed at (City, Province/Territory)

Date (DD / MM / YYYY)

Signature of Applicant

Signature

Advisor Code

ADVISOR'S REPORT

You confirm that you have disclosed the following information to the applicant:

• the name of the company or companies you represent, and

• that you receive a salary for the sale of life, accident and sickness insurance products.

Your Name (first, middle initial, last)

Send your completed and signed payment to Manulife:	d application form along with	CUSTOMER SERVICE:
MAIL: Manulife P.O. Box 670, Stn Waterloo Waterloo, ON N2J 4B8	FAX: 1-888-264-2243	 Monday through Friday from 8 a.m. to 8 p.m. EST) Mam_service@manulife.com ☐ SISIPT100.ca

RESET

PRINT

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

Underwritten by The Manufacturers Life Insurance Company (Manulife).

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