

The Manufacturers Life Insurance Company



SISIP Financial Term 100 (T100) Life Insurance Application Form

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 (Code: C)

CANADIAN ARMED FORCES (CAF) MEMBER SERVICE NUMBER:

□□□□ □□□□ □□□□ M/S/C

CAF Member Service Number
(Please indicate if you are applying as a Member [M], Spouse [S] or Child [C] by entering the appropriate letter at the end of the Member Service Number)

Male Female
Smoker Non-Smoker*

*Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products, including e-cigarettes, in the past 12 months.

Applicant Name: Last First

Home Address: Street Unit/Apt# City Province Postal Code

Date of Birth: DD / MM / YYYY Place of Birth (province, country):

Primary Phone Number: Email:

Occupation:

Part B — Amount of Insurance Applied for (DO NOT include coverage already in force)

APPLICANT COVERAGE AMOUNT

Choose the amount of Term 100 Life Insurance coverage you require. Coverage is available in increments of \$25,000. The minimum coverage amount is \$25,000. The coverage in-force and applied for may not exceed \$100,000.

\$25,000 \$50,000 \$75,000 \$100,000 Add Waiver of Premium Option? Yes No

You must choose the Waiver of Premium Option at the time of Term 100 Life Insurance application. Please see brochure for more information.

PREMIUM PAYMENT OPTIONS

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 insurance coverage with Manulife or any other company?

Yes No If yes, complete the following:

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 your existing coverage until you receive and review your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated. If you are replacing a portion of your existing SISIP Financial term life insurance, no replacement form is needed.

Part C – Beneficiary Information

APPLICANT

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary(ies):

1. Last Name First Name Relationship to You, the Applicant % of Benefit

2. Last Name First Name Relationship to You, the Applicant % of Benefit

Contingent Beneficiary(ies):

1. Last Name First Name Relationship to You, the Applicant % of Benefit

2. Last Name First Name Relationship to You, 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:

Name (Last/First) Relationship to the Beneficiary

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.

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

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 _____ Signature of Account Holder _____

Second Signature If Joint Account _____ 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.

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

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 www.manulife.ca.

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

- 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, printing and distribution services, paramedical and investigative agencies)
- 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

ADVISOR'S REPORT

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

Advisor Code _____

- 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) _____ Signature _____

Send your completed and signed application form along with payment to Manulife:

MAIL:
Manulife
P.O. Box 670, Stn Waterloo
Waterloo, ON
N2J 4B8

FAX:
1-888-264-2243

CUSTOMER SERVICE:

📞 **1-855-887-7809**
(Monday through Friday from 8 a.m. to 8 p.m. EST)

✉️ **am_service@manulife.com**

💻 **SISIPT100.ca**

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

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