APPLICANT'S DECLARATION (All applicants *must* complete this section)

I/We hereby acknowledge that the statements contained herein are true and complete and, together with any other forms signed by me/us in connection with this application, form the basis for any policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third-party administrator (where applicable), any government agency, investigative or security agency or any 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 under this plan, to provide any such information to Manulife or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application, may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy or of coverage for the individual(s) to whom the failure to disclose relates and the continuation of coverage for any remaining insureds. Manulife reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality as stated in the brochure. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

Member Signature *(must sign)* _____ Date (dd/mm/yyyy) _____

Spouse Signature *(when applying for insurance)* _____ Date (dd/mm/yyyy) _____

Signed at *(city and province)* _____

If you have any questions on new enrollment, please call toll-free

1 866 410-0550

or e-mail **am_service@manulife.com**

(Members currently enrolled in the insurance plan, please call 1 800 268-3763)

Manulife

This plan is underwritten by The Manufacturers Life Insurance Company (Manulife).

MF.RWTO.APP(03/16)
16.1116

The Retired Women Teachers of Ontario/
Organisation des enseignantes retraitées de l'Ontario (RWTO/OERO)

Application for Hospital and Home Care AND Personal Accidental Death and Dismemberment Plans

Manulife

When applying for coverage, please follow these steps:

1) Complete, sign and date the application. ***Note that PARTS E & F must be completed in full if, as a member, you have been retired for more than one year, or you are the spouse of a member.***
2) If you choose to have premiums paid by Pre-Authorized Debit (PAD), please ensure that you have also signed PART D and enclose a blank cheque marked **VOID**. If you choose to pay by cheque, you will be billed for payment upon approval of your application.
3) Please mail your application to: Manulife, PO Box 670, Stn Waterloo, Waterloo, ON N2J 4B8.

PLEASE PRINT IN INK

PART A — GENERAL INFORMATION

Member:

First Name _____

Last Name _____ Initial _____

Date of Birth _____ (dd/mm/yyyy)

Date of Retirement _____

Telephone Number _____

Fax Number _____

E-mail Address _____

Address: Apt. #_____ Street _____

City/Town _____ Prov. ____ Postal Code _____

OHIP Number _____

Spouse:

First Name _____

Last Name _____ Initial _____

Date of Birth _____ (dd/mm/yyyy)

Telephone Number _____

Fax Number _____

E-mail Address _____

OHIP Number _____

PART B — PLAN CHOICE

MEMBER *I am applying for: (Check all that apply)*

❑ **a) Hospital & Home Care Plan**

❑ **b) Personal Accidental Death & Dismemberment Plan**

If applying for b), please choose a coverage amount.

❑ Under age 70	❑ 70-79	❑ 80-84*
❑ $ 25,000	❑ $ 12,500	❑ $ 6,250
❑ $ 50,000	❑ $ 25,000	❑ $ 12,500
❑ $ 75,000	❑ $ 37,500	❑ $ 18,750
❑ $100,000	❑ $ 50,000	❑ $ 25,000
❑ $125,000	❑ $ 62,500	❑ $ 31,250
❑ $150,000	❑ $ 75,000	❑ $ 37,500
❑ $175,000	❑ $ 87,500	❑ $ 43,750
❑ $200,000	❑ $100,000	❑ $ 50,000

**Coverage terminates at age 85.*

SPOUSE *I am applying for: (Check all that apply)*

❑ **a) Hospital & Home Care Plan**

❑ **b) Personal Accidental Death & Dismemberment Plan**

If applying for b), please choose a coverage amount.

❑ Under age 70	❑ 70-79	❑ 80-84*
❑ $ 25,000	❑ $ 12,500	❑ $ 6,250
❑ $ 50,000	❑ $ 25,000	❑ $ 12,500
❑ $ 75,000	❑ $ 37,500	❑ $ 18,750
❑ $100,000	❑ $ 50,000	❑ $ 25,000
❑ $125,000	❑ $ 62,500	❑ $ 31,250
❑ $150,000	❑ $ 75,000	❑ $ 37,500
❑ $175,000	❑ $ 87,500	❑ $ 43,750
❑ $200,000	❑ $100,000	❑ $ 50,000

**Coverage terminates at age 85.*

Beneficiary designation for payment of Personal Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Member's Beneficiary _____ (First and Last Name) Relationship to Applicant _____

Please choose: ❑ Revocable ❑ Irrevocable

If you designate a beneficiary under the age of 18, benefits will be paid into court unless a trustee is appointed.

Name of Trustee _____ Relationship to Applicant _____

Spouse's Beneficiary _____ (First and Last Name) Relationship to Applicant _____

Please choose: ❑ Revocable ❑ Irrevocable

If you designate a beneficiary under the age of 18, benefits will be paid into court unless a trustee is appointed.

Name of Trustee _____ Relationship to Applicant _____

PART C — PAYMENT OPTIONS

Initial Payment: I/We hereby authorize Manulife to debit the initial 2 months' premium, $_____, from my/our:
Option 1 ❑ Financial Institution Account (Pre-Authorized Debit – PAD) **Option 2** ❑ Credit Card Account

Subsequent Payments: Will be made by:

Option 1 ❑ **Pre-Authorized Debit (PAD) (Please also complete PART D below)**
Billing Frequency: ❑ Monthly ❑ Semi-Annually ❑ Annually
Important: For verification purposes we require a sample cheque marked "VOID".

Option 2 ❑ **Credit Card: (Please read and sign PART D below)**
Billing Frequency: ❑ Monthly ❑ Semi-Annually ❑ Annually

Option 3 ❑ **Direct Billing:** Billing Frequency: ❑ Semi-Annually ❑ Annually

PART D — PAYMENT INFORMATION and AUTHORIZATION

PAYMENT INFORMATION For Pre-Authorized Debit (PAD) Payment Options

Name of Account Holder _____

Financial Institution _____ Address _____ City/Town _____

Bank Account Number _____ Branch Transit Number _____

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.

PAYMENT AUTHORIZATION For Pre-Authorized Debit (PAD) Payment Options

I/We authorize Manulife to make monthly automatic withdrawals from my/our bank account **on or about the first business day of each month** for monthly insurance premiums due on or after the date I/we sign this authorization. Withdrawals from my/our account may be for variable amounts, as they 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 the 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 for an alternative method of payment if 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 or Manulife may end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in 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.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1 800 268-3763, more_info@manulife.com or write to us at Manulife, PO Box 670, Stn Waterloo, Waterloo, Ontario N2J 4B8.

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, 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) _____

PAYMENT INFORMATION For Credit Card Payment Options

❑ Visa ❑ MasterCard Account Number _____ Expiry Date _____
(MM / YYYY)

PAYMENT AUTHORIZATION For Credit Card Payment Options

I/We hereby authorize Manulife to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This Authorization may be terminated by either Manulife or by me/us through written notice.

Manulife may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) transactions.

Name of Cardholder _____ Signature of Cardholder _____

Second Signature If Joint Account _____ Dated _____
(DD / MM / YYYY)

PART E — MEDICAL QUESTIONNAIRE

Completion of Parts E & F is required if you are an RWTO/OERO member and you have retired more than one year ago OR if you are a spouse of an RWTO/OERO member.

You must disclose any medical condition, injury or illness that occurred or existed on or before the date of your application, regardless of whether you went to see a doctor about the condition or were given a diagnosis, or whether or not you believe that it is important. The coverage offered could be declined and will be determined after an evaluation of the information provided on this medical questionnaire.

If the answer to any of the following questions is "Yes," please provide details below. ***Where applicable, identify each condition and indicate when it started, how long it lasted, degree of recovery and name of attending physician.*** (If additional space is required, please attach a separate sheet of paper.)

	Member Yes	Member No	Spouse Yes	Spouse No	*Please provide details to any "yes" answers and indicate whether they apply to Member or Spouse, in each case.*
1. Height	❑ cm ❑ ft/in		❑ cm ❑ ft/in		
2. Weight	❑ kg ❑ lb		❑ kg ❑ lb		
3. Have you been aware of any pain or health complaint for which a physician has not yet been consulted?	❑	❑	❑	❑	
4. Have you been advised to have any medical treatment or testing which has not yet been completed?	❑	❑	❑	❑	
5. Are you currently receiving treatment or medication or undergoing testing for any disease, disorder or condition?	❑	❑	❑	❑	
6. Have you had any of the following: a) Heart problems or any other related conditions? b) Bone, joint, muscle or spinal problems? c) Stroke, paralysis, diabetes, cancer, kidney or nervous disorders? d) Any other condition requiring medical treatment within the past 2 years?	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑	
7. a) Do you reside in a place other than your own home, apartment or condominium? b) If yes, please specify: ❑ Seniors' residence ❑ Nursing home ❑ A facility that provides health care and convalescent services as part of your residence fee ❑ Other	❑	❑	❑	❑	
8. Are there any restrictions on your daily activity due to any medical condition, including the ability to go outside?	❑	❑	❑	❑	
9. Do you receive assistance from a homemaker, nurse, community service, or any other individual or organization?	❑	❑	❑	❑	

PART F — TREATING PHYSICIANS

	Member	Spouse
Name & Address of Physician		
Date & Reason for Last Consultation		
Diagnosis & Treatment Given		

(If additional space is required, please attach a separate sheet of paper.)