

Part D • Billing Options

Initial Payment: I hereby authorize Manulife Financial to debit the initial 2 months premium, \$ _____, from my:

Financial Institution Account Credit Card Account

Subsequent Payments: Will be made by:

Pre-Authorized Payment Plan (PAP) From My Financial Institution Account (Please also complete PART E below)

Credit Card (Please also complete PART E below): Visa MasterCard Amex Account # _____ Expiry Date _____
(MM / YYYY)

Cardholder _____ Signature of Cardholder _____
(if other than Applicant or Co-Applicant)

PAP/Credit Card Billing Frequency: Monthly Semi-annually Annually

Direct Billing: Direct Billing Frequency: Semi-annually Annually

Important: For verification purposes we require a VOID cheque if payment is being withdrawn from your financial institution account.

Manulife Financial 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 NSF fee will be charged for all NSF transactions.

Part E • Financial Institution • For Pre-Authorized Payment Plan

Name of account holder(s) if different from Applicant _____

Financial Institution _____

Address _____ City/Town _____

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. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

For Pre-Authorized Payment and Credit Card billing options: I/We hereby authorize Manulife Financial 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 Financial or by me/us through written notice.

Signature of account holder

Second signature if joint account

If you require more space to complete any part of this application, please attach a separate sheet.

Applicant's Declaration • All Applicants Must Complete This Section

This plan is underwritten by The Manufacturers Life Insurance Company.

Check here if you do not wish to receive further information and material on Manulife Financial's products.

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 Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial 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. Manulife Financial 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 and the Notice on Information Provided to the AIR MILES® Reward Program. 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.

Signature of Applicant

Signature of Co-Applicant

Dated (DD/MM/YYYY)

This Plan is offered through Manulife Financial (The Manufacturers Life Insurance Company).

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BASE.APPN.E.02/05