Return Completed Application to:
ACAW Trust Funds
Suite 201, 15210-123 Avenue NW
Edmonton AB T5V 0A3

Manulife Financial

Optional Life Application Form

TO BE COMPLETED BY THE PLAN ADMINISTRATOR

ALBERTA CARPENTERS AND ALLIED WORKERS HEALTH & WELLNESS PLAN G0031661
Plan Sponsor Policy #

ELIZABETH LOMBARDO **BETTE L. THOMPSON** **780-477-9131** **780-477-9134**
Manager Contact Phone No. Fax No.

Suite 201, 15210-123 Avenue NW **EDMONTON, ALBERTA** **T5V 0A3**
Plan Sponsor Address Province Postal Code

PLAN MEMBER - Name SIN# Plan Sponsor Signature Date

SECTION 1 - TO BE COMPLETED BY THE PLAN MEMBER

Coverage being applied for:

☐ Optional Life Plan Member $_____ Spouse $_____

☐ Employee Increase in Optional Life Plan Member Current Amount $_____ Total Amount $_____

☐ Spouse Increase in Optional Life Spouse Current Amount $_____ Total Amount $_____

SECTION 2 - TO BE COMPLETED BY THE PLAN MEMBER

PLAN MEMBER - Last Name First Name and Initial Height (ft/in or m/cms) Weight (lbs/kgs) ☐ Male ☐ Female

Home Address Province Postal Code

SMOKING STATUS DECLARATION
Have you used any form of tobacco or cannabis within the last twelve months?
☐ Yes ☐ No

Date of Birth (dd/mm/yy) Place of Birth Home Phone Business Phone

Regular Physician Name Physician Address Date/Reason for last consultation

SECTION 3 - DEPENDENT INFORMATION (IF APPLYING FOR SPOUSAL OPTIONAL LIFE)

SPOUSE - Last Name First Name and Initial Height (ft/in or m/cms) Weight (lbs/kgs) ☐ Male ☐ Female

Home Address Province Postal Code

SMOKING STATUS DECLARATION
Have you used any form of tobacco or cannabis within the last twelve months?
☐ Yes ☐ No

Date of Birth (dd/mm/yy) Place of Birth Home Phone Business Phone

Spouse Regular Physician Name Physician Address Date/Reason for last consultation

PLEASE COMPLETE THE BACK OF THIS FORM AND ENSURE IT IS SIGNED AND DATED

SECTION 4 - TO BE COMPLETED BY THE PLAN MEMBER

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers, please attach a separate sheet (signed & dated) to avoid unnecessary delays in processing this application.	***Member/ Employee*** Yes	No	***Spouse*** Yes	No
1. Have you had any indication of or been treated for:				
a) any disease or disorder of the eyes, ears, nose, mouth or throat, or any allergies including any job-site environmental sensitivity?	☐	☐	☐	☐
b) lung trouble, pneumonia, bronchitis, pleurisy, asthma, emphysema, tuberculosis or other respiratory disorder?	☐	☐	☐	☐
c) dizziness, fainting, convulsions, headaches, migraines, paralysis or stroke, epilepsy, chronic anxiety, burnout, fatigue, depression, or eating disorder?	☐	☐	☐	☐
d) chest pains, palpitations, high blood pressure, phlebitis, rheumatic fever, heart murmur, heat attack or other disorder of the heart or blood vessels?	☐	☐	☐	☐
e) hepatitis, ulcer, hernia, appendicitis, colitis, Crohn's, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver, or gall bladder?	☐	☐	☐	☐
f) sugar, albumin, protein, blood and/or pus in the urine, sexually transmitted disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐	☐	☐
g) any hereditary disorders or diabetes, thyroid or other endocrine disorders?	☐	☐	☐	☐
h) gout, neuritis, sciatica, rheumatism, arthritis, fibromyalgia, disorder of the muscles or bones, including the spine, back or joints?	☐	☐	☐	☐
i) disorder of the skin, breasts, lymph glands, cysts, tumor or cancer?	☐	☐	☐	☐
j) anemia, or other disorder of the blood or have you ever received a blood transfusion or blood products?	☐	☐	☐	☐
2. Have you ever used or dealt in barbiturates, narcotics, or other drugs or hallucinogens, including marijuana and cocaine, except as prescribed by a physician or received or been advised to receive or currently receiving treatment or counseling for the use of alcohol or drugs.	☐	☐	☐	☐
3. Have you had any driving infractions within the last five years?	☐	☐	☐	☐
4. Have you ever tested positive for, been diagnosed with, or told you have Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) disease?	☐	☐	☐	☐
5. Do you participate in organized contact sports or hazardous activities (e.g. mountain climbing, hang-gliding, scuba-diving, parachuting, flying (pilot/crew member), motorized racing?	☐	☐	☐	☐
6. Do you contemplate a trip or taking up residence outside Canada of the USA? (Specify location and duration)	☐	☐	☐	☐
7. Has any application for insurance been rated for higher premium, modified, postponed, declined or rescinded?	☐	☐	☐	☐
8. Are you currently unable to work, whether inside or outside the home? How many work days have you lost due to disability/illness in the last two years? _____	☐	☐	☐	☐
9. Other than above, have you within the last five years:				
a) been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐	☐	☐
b) received medical or surgical attention due to illness or injury?	☐	☐	☐	☐
c) been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐	☐	☐
d) had an electrocardiogram, x-ray or other diagnostic tests with abnormal findings or indicating any health problems?	☐	☐	☐	☐
e) sought any alternative medical treatment, such as Naturopathy, Acupuncture, Chiropractic care, etc?	☐	☐	☐	☐
f) requested or received a pension, benefits or payment because of an injury, sickness or disability?	☐	☐	☐	☐
10. Are you currently pregnant? If so, due date: _____	☐	☐	☐	☐

SECTION 5 - FOR EVERY 'YES' ANSWER GIVEN IN SECTION 4 ABOVE, PLEASE PROVIDE FULL DETAILS, IF NOT ALREADY INDICATED

Question #	Person to whom it applies	Nature of disorder	Date of first occurrence	Current status and treatment

SECTION 6 - DECLARATION AND AUTHORIZATION

I declare that the information in this application is true and complete to the best of my knowledge, and, along with any other forms signed by me for this application, forms the basis for any insurance issued. In the event that I have provided my social insurance number ("SIN"), then, upon approval of this application, I authorize the use of my SIN for the purposes of identification, tax reporting, and the administration of my group benefits.

I authorize my employer or plan sponsor and Manulife Financial, its affiliates, subsidiaries, their authorized employees or service providers including, but not limited to, the Medical Information Bureau, reinsurers, any health care professionals or health or social service establishments, or other organization, institution or person who has knowledge of me, or my health, or my spouse or their health, to collect, use, exchange, or share with or disclose to each other my personal information or the personal information of my spouse, solely for the purpose of underwriting, issuing, administering, and managing my group benefit plan in the course of daily operations. I hereby authorize Manulife Financial, in its discretion, to share any of my health information or the health information of my spouse, with my physician or the physician of my spouse, which ever the case may be.

I understand that Manulife Financial, its affiliates, subsidiaries, their employees and service providers are subject to strict standards and policies to ensure that my personal information is secure and remains confidential. I understand that Manulife Financial does not sell, lease, or trade personal information, and that any personal information collected by Manulife Financial will be kept strictly confidential and is to be used by authorized individuals only. Authorized individuals include employees, agents, or representatives of Manulife Financial in the performance of their job, persons whom I have authorized, or persons permitted by law to use my personal information. I understand that I have the right to request and receive a copy of my personal information maintained by Manulife Financial at any time. However, I also acknowledge that where medical information has been provided to Manulife Financial through a third party, Manulife Financial will release that information to me only through my physician.

A reproduction of this consent is as valid as the original.

_____

Plan Member's Signature (dd/mm/yy)

Declaration by Spouse: I declare that I have read the above Declaration and Authorization, and adopt all of the terms thereof.

_____

Signature of Spouse (if applying) (dd/mm/yy)