Manulife Financial

CANADIAN PACIFIC RAILWAY

Group Benefits
Application and Evidence of Insurability for Optional Life Insurance

INSTRUCTIONS - Please print all answers

1. *Please consult Manulife Financial for type of coverage available under your plan. Check (✓) to indicate the type of coverage for which you are applying.*
   ◯ *PLAN MEMBER ONLY* ◯ *PLAN MEMBER AND SPOUSE* ◯ *PLAN MEMBER, SPOUSE AND DEPENDANTS* ◯ *SPOUSE AND/OR DEPENDANTS*
2. *Please ensure that ALL SECTIONS are completed.*
   Section 1 - Benefit information - For confirmation of current coverage please contact Manulife Financial Group Benefits Customer Service 1-800-268-6195 or 'send a note' from the secure website.
   Sections 2, 3, 4, 5, 6, 7 and 8 - Plan member/spouse information - To be completed by plan member/spouse and submitted to Manulife Financial.
3. *Please print all answers.*
4. ***If required, retain a photocopy for your files.***

1 Benefit information

Plan contract number(s)	Division number	Plan member certificate number	
		Class	**Annual earnings** **$**

Plan sponsor
Canadian Pacific Railway

Optional life amount:

Plan member's present amount of optional life	$______	OR ___ units of $______	OR ___ x salary $______	= $______
Additional amount requested	$______	OR ___ units of $______	OR ___ x salary $______	= $______
Total amount requested	$______	OR ___ units of $______	OR ___ x salary $______	= $______

Spousal optional life amount:

Spouse's present amount of optional life	$______	OR ___ units of $______	OR ___ x salary $______	= $______
Additional amount requested	$______	OR ___ units of $______	OR ___ x salary $______	= $______
Total amount requested	$______	OR ___ units of $______	OR ___ x salary $______	= $______

Dependant optional life amount:

Dependant's present amount of optional life	$______	OR ___ units of $______
Additional amount requested	$______	OR ___ units of $______
Total amount requested	$______	OR ___ units of $______

2 Plan member statement

Note: The address updates should be sent directly to CPR HR Services.

Plan member's name (last, first and middle initial)

Sex	Date of birth (dd/mmm/yyyy)	Home phone number	Business phone number
◯ Male ◯ Female		( )	( )

Height	Weight	
______ m ______ cm ______ ft ______ in	◯ kg ◯ lb	Have you or your spouse, smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? **Plan member** ◯ Yes ◯ No **Spouse** ◯ Yes ◯ No

Name of personal physician (last, first and middle initial) **(For plan member and dependants)**

Address of personal physician (suite/street number, street, apartment)		Physician's phone number
		( )
City	Province	Postal code

(Please complete all pages of this form.)

3 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

Name of beneficiary (last, first and middle initial)	Relationship to plan member
Additional name, if applicable (last, first and middle initial)	Relationship to plan member
Additional name, if applicable (last, first and middle initial)	Relationship to plan member

For designated beneficiaries under the age 18.

I appoint ______________________________ as Trustee to receive any amount due to any beneficiary under the age of 18.

Irrevocability

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.
If spouse is beneficiary, designation is:
◯ Revocable ◯ Irrevocable

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

4 Spousal coverage

Note: you will be the beneficiary of your spouse's insurance, if you are then living, otherwise the beneficiary will be your estate.

Spouse's name (last, first and middle initial)	Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)

Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ◯ Yes ◯ No

5 Dependant coverage

Note: you will be the beneficiary of your dependant's insurance, if you are then living, otherwise the beneficiary will be your estate.

Dependant's name (last, first and middle initial)	Date of birth (dd/mmm/yyyy)
Relationship to plan member	Student status full time student ◯ Yes ◯ No

6 Dependant statement

To be completed when dependants are applying for coverage.

Please provide the following information for each dependant to be insured.

COMPLETE NAME OF ELIGIBLE DEPENDANT	SEX	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (dd/mmm/yyyy)	HEIGHT ◯ m ◯ cm ◯ ft ◯ in	WEIGHT ◯ kg ◯ lbs
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				
	◯ Male ◯ Female				

7 Medical questionnaire

	Plan member	Spouse	Children
1. Have you, within the last three (3) years, had an application for life or health insurance declined, postponed or modified in any way?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
2. Have you, within the last three (3) years, consulted a physician, or been treated, for high blood pressure, chest pain, heart attack, heart murmur, stroke, cancer, tumour, ulcer, colitis, diabetes, asthma, epilepsy, back pain, mental, nervous illness, emotional condition, anxiety or depression, urinary tract infection, sexually transmitted disease, alcoholism, drug addiction, or any disease or disorder of the heart, blood, lungs, liver, kidneys, or urine?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
3. Have you, within the last three (3) years, been told that you had any immune deficiency disorder, including AIDS or AIDS RELATED COMPLEX (ARC), or any generalized enlargement of your lymph glands, or any test results indicating possible exposure to the AIDS virus (e.g. HIV, HTLV-III, LAV)?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
4. Have you had surgery or been hospitalized within the past three years?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
5. Have you consulted a physician or other practitioner within the past sixty days and been advised to have further treatment, examination, diagnostic test, or surgery not already performed?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
6. Have you, during the last five (5) years had X-rays, Electrocardiograms, blood or other special tests, for other than regular medical checkups, taken or currently on any treatment/medication?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
7. Any family history of any inherited or familial disease? (e.g. Huntington's Chorea, diabetes, heart or kidney disease)	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
8. Have you or your dependants:			
(a) flown as a pilot, student pilot or crew member during the last 3 years or have any intention of doing so?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
(b) ever engaged in racing, underwater diving, parachuting or any other hazardous sport or is any such activity contemplated?	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Please specify which activity. ______________________________			

Please provide details below, if you have answered "Yes" to *ANY* questions.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

QUESTION NUMBER	NAME OF PERSON (FIRST & MIDDLE)	DETAILS OR NAME OF CONDITION	DATE AND DURATION	TREATMENT AND RESULTS (RECOVERY OR REMAINING EFFECTS)	NAMES AND ADDRESSES OF PHYSICIANS AND HOSPITALS

8 Certification and authorization

<u>I certify</u> that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **<u>I agree</u>** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **<u>I authorize</u>** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **<u>I am authorized</u>** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **<u>I understand</u>** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **<u>I authorize</u>** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **<u>I understand</u>** that any Coverage shall not become effective until approved by Manulife. **<u>I authorize</u>** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **<u>I agree</u>** a photocopy or electronic version of this authorization is valid. **<u>I acknowledge</u>** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan member's signature	Date signed (dd/mmm/yyyy)
Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form)	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

9 Mailing instructions

Please send the completed form to:

Group Benefits, Flex Benefits Administration
Manulife Financial
380 Weber Street N
PO BOX 1662
WATERLOO ON N2J 5A4