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Manulife Financial

EMPLOYEE ENROLMENT FORM

NAME OF EMBASSY/CONSULATE	EFFECTIVE DATE OF COVERAGE

GROUP POLICY NUMBER	DIVISION NUMBER	EMPLOYEE'S CERTIFICATE NUMBER

SURNAME	FIRST NAME	MIDDLE INITIAL

CANADIAN MAILING ADDRESS	CITY	PROVINCE	POSTAL CODE

SEX	DATE OF BIRTH	TELEPHONE NUMBER
□ Male □ Female	Day_____Month_____Year_____	

FAMILY COVERAGE

□ No □ Yes **If yes, please complete the section below, listing all eligible dependents**

SURNAME	FIRST NAME	RELATIONSHIP	DATE OF BIRTH Day/Month/Year

DECLARATION AND AUTHORIZATION

I declare that as of the date of this application, I, my spouse and/or dependent children are performing our normal activities on a daily basis. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company or any other organization, institution or person that has any records or knowledge of me, my spouse and/or my dependent children, regarding our health, to release to Manulife Financial or their reinsurers, any such information. A fax or photocopy of this authorization shall be valid as the original.

_____ _____

SIGNATURE OF EMPLOYEE **DATE**

MEDICAL QUESTIONNAIRE

During the past 5 years, have you consulted a physician or been hospitalized, had surgery or any tests other routine checkup minor injury or ailment?

Employee:	□ Yes	□ No
Spouse:	□ Yes	□ No
Dependent Children:	□ Yes	□ No
Name: _____	□ Yes	□ No
Name: _____	□ Yes	□ No
Name: _____	□ Yes	□ No

Have you received any treatment for, consulted a physician for or been diagnosed as having heart disease, b circulatory disorder, high blood pressure, stroke, cancer, diabetes, neurological disorder, lung, kidney, dige liver disorder, mental or psychiatric condition, alcohol or drug abuse, AIDS (Acquired Deficiency Syndrome (Aids Related Complex) or HIV (Human Immuno-Deficiency Virus)?

Employee:	□ Yes	□ No
Spouse:	□ Yes	□ No
Dependent Children:	□ Yes	□ No
Name: _____	□ Yes	□ No
Name: _____	□ Yes	□ No
Name: _____	□ Yes	□ No

Do you presently have any physical or mental health impairment or symptoms of illness or disease?

Employee:	□ Yes	□ No
Spouse:	□ Yes	□ No
Dependent Children:	□ Yes	□ No
Name: _____	□ Yes	□ No
Name: _____	□ Yes	□ No
Name: _____	□ Yes	□ No

For each "YES" answer, please provide details in the space below, including dates, duration of illness or con treatment, present status and name and address of physicians consulted. If additional space is required, att separate sheet of paper, dated and signed by you.

_____

_____

_____

_____

_____

Please provide, in the space below, the full name and address of your regular physician.

_____

_____

DECLARATION

The foregoing answers, to the best of my knowledge and belief are true, full complete and correctly recorde understand if any material misrepresentation is contained therein, any group insurance arising from this ap shall be null and void.

_____ _____

Signature of Employee Date