

MANULIFE FINANCIAL EMERGENCY MEDICAL INSURANCE QUESTIONNAIRE

Name of applicants (Last name, first name)	
1. Applicant 1	2. Applicant 2

STEP 1. ELIGIBILITY	Applicant 1	Applicant 2
1. Have you been advised by a physician not to travel at this time?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2. Do you require kidney dialysis?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. Have you ever had a bone marrow or organ transplant (excluding corneal transplant)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. Have you had a heart bypass, angioplasty or heart valve surgery more than ten (10) years ago?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
5. In the last five (5) years, have you been diagnosed with and/or had treatment for metastatic cancer?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
6. In the last six (6) months, have you received chemotherapy and/or radiotherapy and/or other treatment, other than routine follow-up, for cancer (except basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
7. In the last twelve (12) months, have you been prescribed or taken prednisone or oxygen, or been hospitalized (as an in-patient or seen in the emergency department) for a lung condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
8. In the last two (2) years, have you: a) been prescribed or taken Lasix or furosemide for any reason? b) had congestive heart failure?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9. In the last twelve (12) months, have you been hospitalized (as an in-patient or seen in the emergency department) for a heart condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
10. In the last four (4) months, have you been prescribed or taken six (6) or more prescription medications? Do not count the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. Do not count topical medications that go in your ears or eyes or on your scalp or skin except: any form of nitroglycerine or any drug(s) for angina.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
11. In the last three (3) years, have you been diagnosed with and/or had treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any two (2) of the following (if you only have one (1) of the following conditions, answer NO)? • Heart condition • Lung condition (medication includes any puffer(s)/inhaler(s), except a single unrepeated prescription used for a single episode) • Diabetes (treated with medication and/or insulin) • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (including use of aspirin/Entrophen for this condition) • Peripheral vascular disease (blocked or narrowed arteries) • Alzheimer's disease, or any other form of dementia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**ELIGIBILITY REQUIREMENT.** If you must answer "YES" to ANY of the preceding questions, you are not eligible to purchase this insurance. DO NOT complete this questionnaire. Please contact your agent/broker if you wish to obtain a quote for our Individual Medical Underwriting plan. Continue to Step 2 if you are eligible to purchase this insurance.

STEP 2. FIND YOUR RATE CATEGORY.	Applicant 1	Applicant 2
<b>Rate qualification - Part 1</b>		
1. In the last five (5) years, have you been diagnosed with and/or had treatment and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any of the following? • Heart condition • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (including use of aspirin/Entrophen for this condition) • Aneurysm • Peripheral vascular disease (blocked or narrowed arteries) • Diabetes (if treated with medication and/or insulin) • Lung condition (medication includes any puffer(s)/inhaler(s) except a single unrepeated prescription used for a single episode) • Cirrhosis of the liver • Alzheimer's disease, or any other form of dementia, or Parkinson's disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2. In the last five (5) years, have you smoked or used any tobacco products and been prescribed or used any puffer(s)/inhaler(s)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. In the last six (6) months, have you received advice or treatment for a medical emergency more than once in the emergency room of a hospital?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. In the last three (3) months, have you been prescribed or taken a total of three (3) or more medications for high blood pressure (hypertension) and/or a heart condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

If you answered "YES" to ANY of the questions in Step 2 - Part 1, you qualify for Rate Category C.  
If you answered "NO" to ALL the questions in Step 2 - Part 1, you must answer the question in Step 2 - Part 2.

Rate qualification - Part 2	Applicant 1	Applicant 2
1. In the last two (2) years, have you been diagnosed with or received treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any of the the following conditions? • Bowel obstruction or surgery • Diverticular disorder requiring prescription medication or surgery • Gastrointestinal bleeding • Bleeding or perforated ulcer(s) • Chronic bowel disorder • Liver disorder • Pancreatic disorder • Kidney disorder (including stones) • Gallbladder disorder (including stones. If gallbladder has been removed, answer NO).	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Diverticular disorder requiring prescription medication or surgery	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Gastrointestinal bleeding	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Bleeding or perforated ulcer(s)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Chronic bowel disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Liver disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Pancreatic disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Kidney disorder (including stones)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
• Gallbladder disorder (including stones. If gallbladder has been removed, answer NO).	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

If you answered "YES" to two (2) or more conditions listed in Step 2 - Part 2, you qualify for Rate Category C.  
If you answered "YES" to one (1) condition listed in Step 2 - Part 2, you qualify for Rate Category B.  
If you answered "NO" to ALL the conditions listed in Step 2 - Part 2, you must answer the questions in Step 2 - Part 3.

Rate qualification - Part 3	Applicant 1	Applicant 2
1. In the last two (2) years, have you been diagnosed with, and/or been hospitalized (as an inpatient or seen in the emergency department), and/or received treatment, and/or been prescribed medication by a Hematologist or an Internist for a blood disorder?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2. In the last twelve (12) months, have you been prescribed or used a puffer/inhaler?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. In the last twelve (12) months, have you been diagnosed with or received treatment for cancer, other than routine follow-up (except basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. Are you over 65, and have you had a fall that you reported to a physician in the last six (6) months?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

If you answered "YES" to ANY of the questions in Step 2 - Part 3, you qualify for Rate Category B.  
If you answered "NO" to ALL the questions in Step 2 - Part 3, you must answer the question in Step 2 - Part 4.

Rate qualification - Part 4	Applicant 1	Applicant 2
1. In the last two (2) years, have you smoked or used any tobacco products?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

If you answered "YES" to the question in Step 2 - Part 4, you qualify for Rate Category A. If you answered "NO" to the question in Step 2 - Part 4, you qualify for Rate Category A+.

**IMPORTANT:** The rate category you qualify for determines the pre-existing condition exclusion that applies to your coverage. The pre-existing condition exclusions are detailed on page 1 of this form.

**Rate category**  
I am 55 years of age or older and based on my answers above, I qualify for the following rate category:  
Applicant 1:  A+  A  B  C  
Applicant 2:  A+  A  B  C

I declare that all the information I have provided on this medical questionnaire is true and complete. I understand that if I misrepresent any material information provided in this application, Manulife Financial will void my policy and I will not be covered for any benefits under this policy.

Applicant 1 signature	Applicant 2 signature	Date signed (mm/dd/yyyy)
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