ONTARIO NURSES' ASSOCIATION

Voluntary Life, Accidental Death and Dismemberment and/or Long Term Disability Insurance

Ontario Nurses' Association Benefit Program – APPLICATION

Part 1 – Member Information (Complete this section even if applying for Spousal Coverage only)

PLEASE PRINT CLEARLY

First Name and Middle Initial(s) | Last Name | Date of Birth (DD/MM/YYYY) | ☐ Smoker* ☐ Non-smoker** ☐ M ☐ F

Address – Street/Apt. No. | City/Town | Province/Territory | Postal Code

Employer Name | Date of Hire (DD/MM/YYYY) | ONA Member No. | Date of ONA Membership (DD/MM/YYYY)

Home Telephone No. | Work Telephone No. | Ext. | Home E-mail Address | Work E-mail Address

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Retired

Spousal Information (complete if applying for Spousal Life or AD&D Insurance coverage)

First Name and Middle Initial(s) | Last Name | Date of Birth (DD/MM/YYYY) | Place of Birth | ☐ Smoker* ☐ Non-smoker** ☐ M ☐ F

*Smoking status is only needed for Term Life Insurance products

**Non-smoker rates apply to someone who has not used any form of tobacco or tobacco cessation products, including the use of e-cigarettes or vaporizers within the past 12 consecutive months

Please refer to the Open Enrollment Eligibility section below.

Part 2 – Other Insurance

Your combined coverage must not exceed 67% of your last year's average gross monthly earned income. In the event of a claim, your benefit amount may be reduced by other sources of income.

Do Member and Spouse have any pending or existing life or disability insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Company Name	Type of insurance	Personal or Business	Coverage Amount	Waiting Period	Benefit Period	Taxable?	Will this coverage be replaced?
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Applicant Occupation | Applicant Annual Earned Income (income after expenses and before taxes) | Applicant Net Worth (assets minus liabilities)

Spouse Occupation | Spouse Annual Earned Income (income after expenses and before taxes) | Spouse Net Worth (assets minus liabilities)

Part 3 – Selecting Your Coverage

A. *Long Term Disability* Insurance (LTD) — *Available to ONA Members ONLY*

Members without employer-sponsored LTD coverage are covered (through member dues) for a Base Plan monthly benefit of $250. Choose the additional voluntary monthly benefit amount that would meet your financial needs.

Are You Actively at Work? ☐ **Yes** ☐ **No** **If No, you will be eligible to apply for LTD upon your return to an Actively at Work status.**

Select Your LTD Coverage† Amount:

☐ $250 ☐ $750 ☐ $1,250 ☐ $1,750 ☐ $2,250 ☐ $2,750 ☐ $3,250 ☐ $3,750 ☐ $4,250 ☐ $4,750 ☐ $5,250 ☐ $5,750

☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500

†**Note:** The maximum amount of monthly coverage available is 67% of last year's T4 income, to a maximum benefit level of $6,000 including your $250 Base Plan coverage. Please refer to the calculation tool in the rate sheet.

Open Enrollment Eligibilty:
If you qualify for Open Enrollment, you can apply for LTD without completing Parts 4 and 5. To qualify, you must be Actively at Work and your application must be received by Johnson Inc., within 60 days of: ☐ the first day you became a new ONA Member; or
☐ the day you lost coverage due to a change from full-time to part-time status.

Note: • Loss of coverage must have been through no fault of your own; and
• The level of replacement coverage cannot exceed that which was lost.

Do you qualify for the 60-Day Open Enrollment?

☐ **YES** — If losing/lost coverage, please include a letter from your employer confirming the specific benefit(s) lost with the amount, the date, and the reason(s).

If YES, you do not need to complete Parts 4 and 5. Simply authorize Part 6 and sign and date Part 8 of the application form and send it to Johnson. Inc.

Date coverage ended/will end (If applicable) DD/MM/YYYY

☐ **NO** — You must complete Parts 4 and 5. LTD coverage will be subject to underwriting review and may be approved with exclusions or declined.

B. *Life* Insurance and *Accidental Death & Dismemberment* Insurance

Select Your Life Insurance Coverage:

Note: 10% premium reduction applies to coverage amounts of $150,000 or greater.

Member: ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000
☐ $75,000 ☐ $125,000 ☐ $175,000 ☐ $225,000 ☐ $275,000 ☐ $325,000 ☐ $375,000 ☐ $425,000 ☐ $475,000

Spouse: ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000
☐ $75,000 ☐ $125,000 ☐ $175,000 ☐ $225,000 ☐ $275,000 ☐ $325,000 ☐ $375,000 ☐ $425,000 ☐ $475,000

Select Your Accidental Death & Dismemberment Insurance (AD&D) Coverage:

Member: ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000
Spouse: ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

Beneficiary Designation(s) (Applies to Life and AD&D only)

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Member Beneficiary(ies):

1. _____ _____ _____ _____
Last Name | First Name | Relationship to Applicant | % of Benefit

2. _____ _____ _____ _____
Last Name | First Name | Relationship to Applicant | % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

_____ _____ _____
Last Name | First Name | Relationship to the beneficiary

Spousal Beneficiary(ies):

1. _____ _____ _____ _____
Last Name | First Name | Relationship to Applicant | % of Benefit

2. _____ _____ _____ _____
Last Name | First Name | Relationship to Applicant | % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

_____ _____ _____
Last Name | First Name | Relationship to the beneficiary

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Parts 4 and 5 must be completed by all Life Insurance applicants and LTD Late Applicants.

Part 4 – Non-Medical Information

Have you:	Member	Spouse (if applicable)
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason: fgfdgdfg dgffgdg	☐ Yes ☐ No	☐ Yes ☐ No
2. a) In the past 5 years, have you been charged with or convicted of careless or dangerous driving or had your license suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a license suspension or revocation, provide details including date the license was suspended or revoked.	☐ Yes ☐ No	☐ Yes ☐ No
b) Within the past 2 years, have you been charged with or convicted of 2 or more moving or traffic violations? (for example, speeding, failure to stop, seat belt violations, distracted driving, or failure to provide a breathalyzer sample) If yes, to a) or b) above, please provide full details; nature of offence(s), date(s), driver's license # and licensing province:	☐ Yes ☐ No	☐ Yes ☐ No

Have you:	Member	Spouse (if applicable)
3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s): _____	☐ Yes ☐ No	☐ Yes ☐ No
4 a) Within the next 12 months do you expect to travel outside of Canada and the United States of America? If "yes", give details including where, when, why and for how long: _____	☐ Yes ☐ No	☐ Yes ☐ No
b) Do you expect to change your country of residence? If "yes", provide details, including where you intend move, when you are moving, why you are moving, and if your occupation is changing _____	☐ Yes ☐ No	☐ Yes ☐ No
5. Within the past 5 years, have you used any drugs for other than medical purposes, used cannabis, or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug or alcohol type(s) and date(s) last used: _____	☐ Yes ☐ No	☐ Yes ☐ No
6. Within the past 5 years have you been convicted of a criminal offense or are you currently charged with one? If yes please provide details _____	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past 5 years have you declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge _____	☑ Yes ☐ No	☐ Yes ☐ No

Part 5 – Medical Declaration

Member Information

Name of Applicant:_____ Physician's Name: _____

Physician's Address and telephone number: _____

Date, reason, and result of last consultation, and if any treatment or medication prescribed: _____

Height _____ ft and in/cm Weight: _____ lb/kg

Has your weight changed by more than 10 pounds (4.5 Kg) in the past 12 months? ☐ Yes ☐ No If yes: _____ lb/kg ☐ Gained ☐ Lost

Reason for change: _____

Spouse Information

Name of Applicant:_____ Physician's Name: _____

Physician's Address and telephone number: _____

Date, reason, and result of last consultation, and if any treatment or medication prescribed: _____

Height _____ ft and in/cm Weight: _____ lb/kg

Has your weight changed by more than 10 pounds (4.5 Kg) in the past 12 months? ☐ Yes ☐ No If yes: _____ lb/kg ☐ Gained ☐ Lost

Reason for change: _____

IMPORTANT: Any reference to testing, tests, test results or investigations in this section excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

Have you ever had any indication of or been treated for conditions involving any of the following:	Member	Spouse (if applicable)
1. **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐ Yes ☐ No	☐ Yes ☐ No
2. **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐ Yes ☐ No	☐ Yes ☐ No
3. **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐ Yes ☐ No	☐ Yes ☐ No
4. **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐ Yes ☐ No	☐ Yes ☐ No
5. **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐ Yes ☐ No	☐ Yes ☑ No

Have you ever had any indication of or been treated for conditions involving any of the following:	Member	Spouse (if applicable)
6. **Your brain or nervous system** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐ Yes ☐ No	☐ Yes ☐ No
7. **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐ Yes ☐ No	☐ Yes ☐ No
8. **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐ Yes ☐ No	☐ Yes ☐ No
9. **Your blood or glands**, such as: Diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, bleeding tendency, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐ Yes ☐ No	☐ Yes ☐ No
10. **Your muscles, bones, or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?	☐ Yes ☐ No	☐ Yes ☐ No
11. **Your skin**, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐ Yes ☐ No	☐ Yes ☐ No
12. **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐ Yes ☐ No	☐ Yes ☐ No
13. Cancer, cysts, lumps, polyps, or tumour?	☐ Yes ☐ No	☐ Yes ☐ No
14. Other illness or disorder not mentioned above or, are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐ Yes ☐ No	☐ Yes ☐ No
15. Are you currently pregnant? If "Yes", give due date and the name and address of your obstetrician/gynecologist: _____ a) What was your pre-pregnancy weight _____ lbs _____ kg	☐ Yes ☐ No	☐ Yes ☐ No
b) Have there been any complications with your pregnancy? If "Yes" provide details. _____	☐ Yes ☐ No	☐ Yes ☐ No
During the past 5 years (Spouses are not required to answer questions 16 to 20):		
16. Have you been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain sciatica, or other?	☐ Yes ☐ No	☐ Yes ☐ No
17. Had X-rays (including the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐ Yes ☐ No	☐ Yes ☐ No
18. Have you been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No
19. Been hospitalized or been medically disabled for more than two consecutive weeks?	☐ Yes ☐ No	☐ Yes ☐ No
20. Have you consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	☐ Yes ☐ No	☐ Yes ☐ No
21. Have you been successfully vaccinated against hepatitis B? If no, provide details. If yes, provide date. _____	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 2 years:		
22. Had an abnormal mammogram, PSA or any other test or investigation?	☐ Yes ☐ No	☐ Yes ☐ No
23. Consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu, etc.)	☐ Yes ☐ No	☐ Yes ☐ No
24. Been advised to undergo further investigation, seen another doctor or have surgery?	☐ Yes ☐ No	☐ Yes ☐ No
25. Are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to any of the preceeding questions, please give details below

Question #	Nature of Disorder	Date and Duration	Treatment (If None, State "None") & Current Status	Attending Physician or Hospital

Your Family Medical History	Member	Spouse (if applicable)
1) Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2) Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, retinitis pigmentosa?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, to 1) or 2) above, please complete the following:

Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause, if applicable

If required, additional information can be provided on a separate page. Please sign and date your attachments.

Part 6 – Your Payment Method

Authorization

☐ **AUTOMATIC BANK WITHDRAWAL AUTHORIZATION:** I authorize Johnson Inc., the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance (for example, the April 5th deduction pays for May coverage). Due to application processing time and the effective date of coverage, the initial deduction may cover more than one month of premium. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non-Sufficient Funds (NSF) notices on my account.

☑ **CLAIMS PAYMENT DIRECT DEPOSIT AUTHORIZATION:** I authorize Johnson Inc. to deposit my Extended Health Care (EHC) and Dental claims reimbursements directly into my bank account.

☑ I have enclosed a **sample cheque marked "VOID"** to be used for automatic bank withdrawals and claims reimbursements.

Part 7 – Personal Information Statement

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract, the insured providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, or driver's license
- Medical information that any organization or person has about you
- Any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test.
- Your personal information from MIB, Inc., as explained in Information about MIB, Inc.
- A copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or a consumer report from other organizations, person or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics, and interests
- Other personal information we may require to administer our business relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company
  - Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your policy now, and in the future
  - Public sources, such as government agencies and internet sites

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the policy
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons, financial institutions and other parties with whom we deal in issuing and administering your policy now, and in the future
- Authorized employees, agents and representatives
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your medical doctor
- Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:
- will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- will be shared with all the owners and any subsequent owners of those contracts and all people to be insured

How long do we keep your information?

The longer of:
- the time period required by law and by guidelines set for the financial services industry, and
- the time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care center at 1-888-MANULIFE (626-8543), or 1-888-MANUVIE (626-8843) in Quebec, or write to the Privacy Officer at the address below.

Accuracy and Access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question or a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer Manulife: P.O. Box 1602 500 King Street N Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Part 8 – Declaration and Authorization

I /We (the Member/Spouse) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I declare that the statements contained in this application, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any coverage issued hereunder. I understand that any material misrepresentation including misstatement of smoker status shall render the insurance voidable at the instance of the insurer, and that suicide within two years of the effective date is a risk not covered. I understand that there are exclusions and limitations on the coverage applied for.

Relative to the insurance applied for, I, the undersigned person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic, or other medically related facility, insurance company, the MIB Inc., the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker, or market intermediary, any government agency, or other organization or person that has any records or knowledge of me or my health to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose. I authorize Manulife to hold a personal file about myself and my insurance coverage. I authorize Manulife, the plan administrator, and their authorized staff, agents, representatives, advisors, and service providers to use and exchange information needed for underwriting, financial management, administration, and adjudication of claims under this insurance coverage with any person or organization who has relevant information about me including institutions, investigative agencies, insurers, and reinsurers. A photocopy or faxed copy of this authorization shall be as valid as the original.

I declare that I have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. I understand that this consent may be revoked at any time and that, if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

I understand that in connection with this application, Manulife may request a medical examination, urinalysis, or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant, and that any positive infectious disease results will be reported to the appropriate health department if required by law.

I/We hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

I/We acknowledge my/our receipt of and agreement with the Personal Information Statement and Notice of Exchange on Information.

If my/our application is approved, I/we will receive a certificate specifying the coverage provided and the main certificate provisions.

Signature of Member	City	Province/Territory	Date DD/MM/YYYY
Signature of Spouse (if applying for coverage)	City	Province/Territory	Date DD/MM/YYYY

For more information contact Johnson Inc.

Toll-free: 1-800-461-4155
Fax number: 1-866-623-8257
Website: ona.johnson.ca

PLEASE MAIL YOUR APPLICATION TO:

Johnson Inc., PO Box 4216, Station A, Toronto, ON, M5W 5M7

JOHNSON INSURANCE Manulife ONTARIO NURSES' ASSOCIATION

538001 001 (Life) 538001 002 (LTD) 02-24

Notice on Exchange of Information: Information about MIB, Inc. We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, Inc. based on your application, or to other insurance companies to which you apply for life, health, or critical illness insurance, or to which a claim for benefits has been made. MIB, Inc. is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, Inc. will share any information it has on file. You may review the information in your file, and request a correction if necessary, by contacting MIB, Inc. at: MIB, Inc., 330 University Avenue, Suite 501 Toronto, Ontario M5G 1R7 Telephone: (416) 597-0590 Fax: (416) 597-1193 Email: canada_disclosure@mib.com