How to apply for coverage.

1. Each person (member, spouse, parent, and/or adult child) applying for Long Term Care coverage must complete and submit an Application for Coverage.
2. Not everyone will be eligible for this coverage. Before you begin to complete the Application, please review the questions in Part 3. If ANY question in Part 3 is answered "YES", you are not eligible for this coverage and should not submit an Application.
3. When completing the Application, please print in black or blue ink.
4. Actively at Work Teachers must complete Parts 1, 2, 3, 4, and 7. Teachers who do not meet the Actively at Work criteria may apply by completing the entire application.
5. All other Applicants must complete ALL Parts of the Application, except Part 2.
6. Select your coverage in Part 4 after reviewing your LTC brochure and rate sheet provided by Johnson Inc.
7. Be sure to sign and date your Application in "Part 7: Declaration and Authorization" on page 8.
8. Please mail your completed Application for Coverage (in the postage-paid envelope provided) to:

   Johnson Inc., Plan Benefits Service

   1595 16th Avenue, Suite 700

   Richmond Hill, ON L4B 3S5
9. If you require assistance in completing your Application or have any questions about the Long Term Care Plan, please call a Johnson Inc. Service Supervisor:

   Toll Free: 1.877.LTC.PLAN (1.877.582.7526)

What to expect once you submit your Application.

As part of the underwriting process, a representative of The Manufacturers Life Insurance Company (Manulife Financial) will contact you by telephone to review your Application and medical history.

For applicants age 75 or older, the underwriter will request a face-to-face meeting between you and a registered nurse. Please note: the underwriter reserves the right to request medical records or a face-to-face meeting for any individual for whom at the underwriter's discretion this information is necessary to properly evaluate the request for coverage.

We will inform you of our decision to issue the coverage you requested within four to six weeks of our receiving your completed Application. An incomplete Application may be returned to you without review.

Once your application is approved, we will assign a Policy Effective Date, dated the 1st of the month following Application approval.

The Long Term Care Plan is underwritten by The Manufacturers Life Insurance Company (Manulife Financial) and administered by Johnson Inc.

Internal Use Only. Prescreen #: ________________________ Application #: ______________________________

Long Term Care Insurance - Application for Coverage

PLEASE PRINT

PART 1: APPLICANT'S PERSONAL INFORMATION (to be completed by each Applicant).

Name of Sponsoring Group: ______________________________

Internal Use Only. Group Number: ____________

Group Member's Name: ______________________________

Group Member's Identification Number: ______________________________

Applicant's Last Name: ______________________________

Applicant's First Name: ______________________________

Applicant's Social Insurance Number: ______________________________

Applicant's Relationship to Group Member: ______________________________

Gender:
❍ Male ❍ Female

Marital Status:
❍ Married ❍ Single ❍ Other (Specify) ______________________

Date of Birth: ______ / ______ / ______
Day / Month / Year

Place of Birth: ______________________________
City / Province

Address:
Street / Box / R.R. ______________________________
Apt. No. ______________________ City ______________________________
Province: ______________________________ Postal Code ______________________

Telephone: ( ) ________ ____________ Best Time to Call: ❍ a.m ________ ❍ p.m. ________
Email: ______________________________

PART 2: ACTIVELY AT WORK TEACHER

Complete this section if you are a member of the sponsoring Group, under age 65 and currently employed as a teacher.

Date of Hire (Day/Month/Year): ______________________ Current Employer: ______________________________

Hours Worked per Week: ____________ Number of personal sick days taken in the last 6 months: ____________

1. Have you been teaching for your current employer for less than six months? .... YES ❏ NO ❏
2. Do you work for your current employer for less than twenty hours a week?.................................... YES ❏ NO ❏
3. In the last six months, have you taken more than five days off work due to your own sickness or injury?.. YES ❏ NO ❏

If you answered "NO" to questions 1-3 above, complete PART 3 and PART 4 on the next page and sign "PART 7: Declaration and Authorization" of this Application.

If you answered "YES" to ANY of the questions above, please complete the entire Application for Coverage.

PART 3: INSURABILITY INFORMATION

Please review the following questions before completing the section; if you answer "YES" to any, you are not eligible for Long Term Care coverage.

1. Do you have or have you been advised by a member of the medical profession that you have any of the following:

Condition			Condition		
AIDS	YES ❑	NO ❑	Multiple Sclerosis	YES ❑	NO ❑
AIDS-related Complex	YES ❑	NO ❑	Muscular Dystrophy	YES ❑	NO ❑
Alzheimer's Disease	YES ❑	NO ❑	Organ Transplant	YES ❑	NO ❑
Amputation due to Disease	YES ❑	NO ❑	Organic Brain Syndrome	YES ❑	NO ❑
ALS (Lou Gehrig's Disease)	YES ❑	NO ❑	Osteoporosis with Fractures	YES ❑	NO ❑
Cirrhosis of the Liver	YES ❑	NO ❑	Paralysis	YES ❑	NO ❑
Forgetfulness	YES ❑	NO ❑	Parkinson's Disease	YES ❑	NO ❑
Dementia	YES ❑	NO ❑	Schizophrenia	YES ❑	NO ❑
HIV	YES ❑	NO ❑	Scleroderma	YES ❑	NO ❑
Memory Loss	YES ❑	NO ❑	Systemic Lupus Erythematosus	YES ❑	NO ❑
Multiple Strokes (2 or more)	YES ❑	NO ❑	Multiple TIAs (2 or more)	YES ❑	NO ❑
Diabetes treated with Insulin	YES ❑	NO ❑	Huntington's Chorea	YES ❑	NO ❑

Please check "YES" or "NO" to each question. If "YES", circle all diagnoses or conditions that apply.

2. Are you residing in a Nursing Home, a Chronic Care Facility, a Complex Continuing Care Facility, a Personal Care Home, an Adult Residential Care or Assisted Living Facility, or are you receiving Home Health Care or Home Support Services? .... YES ❑ NO ❑

3. Are you attending Adult Day Care? .... YES ❑ NO ❑

4. Do you need assistance from or supervision by another individual for dressing, eating, continence, bathing, toileting, walking or transferring to or from a bed or chair? .... YES ❑ NO ❑

5. Do you currently use crutches, oxygen, respirator, dialysis, walker, wheelchair, multi-prong cane, motorized scooter, stairlift or catheter? .... YES ❑ NO ❑

PART 4: COVERAGE SELECTION

I wish to apply for the following Long Term Care Plan coverage:

❑ **Plan A**	❑ **Plan B**	❑ **Plan C**
$50 Daily Benefit Maximum	$75 Daily Benefit Maximum	$100 Daily Benefit Maximum
$50,000 Maximum Lifetime Benefit	$100,000 Maximum Lifetime Benefit	$200,000 Maximum Lifetime Benefit
Monthly Premium: ________	Monthly Premium: ________	Monthly Premium: ________

The monthly premium shown is based on your age as of the date you sign this Application.

A couple/family discount of 10% will also apply after both/all Applications are approved.

PART 5: MEDICAL QUESTIONNAIRE

1. Height: ______________ feet & inches OR ______________ cm

Weight: ______________ lbs OR _______________ kg

Waist Measure: ___________ inches OR _________ cm

2. In the last 10 years, have you had, been diagnosed with or treated for any of the following?

For each "YES" answer, please circle the condition and give details in the space provided on the following page.

a) Alcoholism or Drug Addiction .... YES ❑ NO ❑

b) Anemia, Polycythemia, Thombocytopenia, Thrombocythemia, Hemochromatosis .... YES ❑ NO ❑

c) Rheumatoid Arthritis, Osteoarthritis, Degenerative Joint Disease, Spinal Stenosis, Joint Replacement Surgery .... YES ❑ NO ❑

d) Osteoporosis, Osteopenia, Scoliosis, Degenerative Disc Disease .... YES ❑ NO ❑

e) Ankylosing Spondylitis, Fibromyalgia, Polymyalgia Rheumatica, Chronic Fatigue Syndrome YES ❑ NO ❑

f) Cancer, Melanoma, Tumor, Hodgkin's Disease, Lymphoma, Leukemia or Bone Marrow Disorder .... YES ❑ NO ❑

g) Depression, Anxiety, or Psychiatric Disorder .... YES ❑ NO ❑

h) Diabetes or Disorder of Glucose Metabolism .... YES ❑ NO ❑

i) Epilepsy, Seizures, Dizziness, Falls, Imbalance, Paralysis, Tremor, Neuropathy, Mental Retardation .... YES ❑ NO ❑

j) Glaucoma, Cataract, Macular Degeneration or Vision Impairment, Hearing Loss .... YES ❑ NO ❑

k) Coronary Artery Disease, High Blood Pressure, Heart Arrhythmia, Cardiomyopathy, Congestive Heart Failure .... YES ❑ NO ❑

l) Stroke, Transient Ischemia Attack (TIA), Carotid Artery Disease, Peripheral Vascular Disease, Aneurysm .... YES ❑ NO ❑

m) Disorder of the Kidney or Bladder, Urinary Incontinence, Prostate Disorder .... YES ❑ NO ❑

n) Emphysema, Asthma, Chronic Obstructive Pulmonary Disease, Tuberculosis, Chronic Bronchitis, Chronic Lung Disease .... YES ❑ NO ❑

o) Hepatitis, Ulcerative Colitis, Crohn's Disease, Ulcer, Pancreatitis .... YES ❑ NO ❑

3. Has it been recommended that you have any surgery, tests or procedures that have not been performed? .... YES ❑ NO ❑

4. Within the last 5 years have you been hospitalized, consulted with or been treated by a physician for any disease or condition not previously stated in the above Application questions? .... YES ❑ NO ❑

PART 5: MEDICAL QUESTIONNAIRE (continued)

Details for all "YES" answers to questions 2, 3 and 4. If additional space is needed, attach a separate sheet with Applicant's signature and date.

Question #	Condition	Date of Onset	Treatment	Treating Physician or Facility Name, Address and Phone

5. List all medications you are currently taking including nonprescription medications. ❏ *Check here if not taking any.*

Medication	Dosage	Reason Prescribed	Prescribing Physician Name

6. Complete the following on your Primary Care Physician. ❏ *Check here if you do not have a Primary Care Physician.*

Physician Name	Address	Phone	Date and reason last seen

7. Other Physician(s) you have seen in the last 5 years. ❏ *Check here if you have not seen any other Physician(s).*

Physician Name	Address	Phone	Date and reason last seen

PART 6: PERSONAL PROFILE

1. Do you participate in any of the following?

YES	NO	Activity	Details, if "YES" was checked	
❑	❑	Work	Hours/week:	Occupation:
❑	❑	Volunteer	Hours/week:	Specifics:
❑	❑	Exercise	Hours/week:	❑ Walk ❑ Run ❑ Weights ❑ Aerobics ❑ Bike ❑ Other ____________
❑	❑	Social Activities	Specifics:	
❑	❑	Hobbies	Specifics:	

2. Have you used tobacco products (cigarettes, pipe, cigar, chewing tobacco, snuff) in the last 12 months? .... YES ❑ NO ❑

If "YES", Type: ______________ Frequency: ____________ Duration of use: ____________

3. Do you currently drink alcoholic beverages? .... YES ❑ NO ❑
Number of drinks a day: ❑ 1 or less ❑ 2 ❑ 3 ❑ 4 or more
Type(s) of alcohol consumed: ❑ Beer ❑ Wine ❑ Hard liquor

4. Are you receiving disability income, Workers' Compensation, or any other provincial or federal disability benefits?........ YES ❑ NO ❑

5. Do you currently require assistance or supervision with laundry, taking medication, grocery shopping, housekeeping, transportation, meal preparation, using the telephone or handling personal finances?........ YES ❑ NO ❑

6. Have you ever resided in a Nursing Home, a Chronic Care Facility, a Complex Continuing Care Facility, a Personal Care Home, an Adult Residential Care or Assisted Living Facility, or received Home Health Care or Home Support Services, or attended Adult Day Care? .... YES ❑ NO ❑

7. Have you ever had an application for Long Term Care Insurance declined, postponed, modified or rated?........ YES ❑ NO ❑

8. Do you have an active Power of Attorney and/or guardianship over your affairs? .... YES ❑ NO ❑

If you answered "YES" to any of questions 4-8 above, provide full details below.

Question #	Details	Date

Part 7: Declaration and Authorization

I declare that the statements made on this application are true and complete and form part of any policy issued.

I agree that acceptance of any policy issued constitutes approval of the provisions of the policy and ratifications of any additions, endorsements or amendments. I agree that any policy issued takes effect on the Policy Effective Date, following application approval, policy delivery and full payment of the first premium, and then only if there has been no change in my insurability, subsequent to the completion of this application. I also understand that I may be contacted in person or by telephone by a representative of The Manufacturers Life Insurance Company (Manulife Financial), or by Johnson Inc., the Plan Administrator, as part of the underwriting process.

It is understood and agreed, that the application and any questionnaire(s) is comprised of questions pertaining to my personal and medical information. I have read and received the Notice on Privacy and Confidentiality. I authorize Manulife Financial, its participating reinsurers and authorized representatives, to collect, use and disclose personal information concerning me for the purpose of determining my eligibility for insurance; underwriting and administering coverage, and adjudicating and paying claims. I authorize Manulife Financial to exchange the personal information obtained during review of this application, or any claim made under the policy issued with Manulife Financial and its reinsurers. I further authorize Manulife Financial to include this personal information in any other files, which Manulife Financial currently holds in respect of me, or which may be opened in the future. I also authorize Manulife Financial to refer to any existing files, opened or closed that they currently hold regarding me.

I authorize any health care providers, insurance companies, the Medical Information Bureau, consumer reporting agency, financial institution, or employer having information about my physical or mental condition, financial status, employment status, or other relevant information about me, to give all information to Manulife Financial, or its reinsurers, and Johnson Inc. to determine eligibility for insurance or benefits. I agree this authorization is valid for 24 months from the Policy Effective Date, or any reinstatement date. A copy is as valid as the original. I, or my authorized representative, can receive a copy upon request. I understand that Manulife Financial may request all records pertaining to my medical history, services rendered, or treatment given to me. I understand that: (1) I can revoke this authorization at any time by written request to Manulife Financial; (2) revocation of this authorization will not affect any prior action taken by Manulife Financial in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair Manulife Financial's ability to evaluate and process the application and may be a basis for denying this application.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE FINANCIAL) HAS THE RIGHT TO DENY BENEFITS OR RESCIND YOUR LONG TERM CARE INSURANCE POLICY.

Part 7: Declaration and Authorization (continued)

Check the Appropriate Box:

❏ **I am a RTAM Member:** I am in receipt of a Teachers' Retirement Allowances Fund (TRAF) Pension (No. _______________ found on the top right corner of any letter from TRAF). I authorize TRAF to deduct from my pension payment the amount of my insurance premium (including mid-term adjustments and arrears) payable to Johnson Inc. (the initial deduction may cover up to 3 months of premium) for monthly premiums due based on the effective date of my policy.

❏ **I am a RTAM Member:** I am not in receipt of a TRAF pension. I have enclosed a sample cheque marked "VOID". 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 (the initial deduction may cover up to 3 months premium) for monthly premiums due based on the effective date of my policy.

❏ **I am an Eligible Applicant:** I have enclosed a sample cheque marked "VOID". I authorize Johnson Inc., the Plan Administrator, to make monthly deductions from the bank, trust company or credit union account shown on the cheque (the initial deduction may cover up to 3 months of premium) for monthly premiums due based on the effective date of my policy.

This Authorization shall remain in effect until written notice is received from me that it should be cancelled.

Dated at ___________________________________, the ___________ day of_____________________, 20_________

Applicant's Signature: ______________________________ Witnessed by ____________________________________

Part 8: Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of personal information about you, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, administer services, and process claims.

Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting) and investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Access to information which is provided to Johnson Inc., the Plan Administrator, and which Johnson Inc. obtains in its capacity as administrator of the Plan, will be restricted to those employees of Johnson Inc., who are responsible for the marketing and administration of services and the facilitation of claims, and to any other person you authorize or as authorized by law. Further information concerning the collection, use and disclosure of personal information by Johnson Inc. may be found in Johnson Inc.'s Privacy Policy available at **www.johnson.ca** or by request.

You may request to review the personal information contained in your file and to make corrections by writing to Johnson Inc. at 1595 16th Avenue, Suite 700, Richmond Hill, Ontario L4B 3S5.

The application review process will be performed at Johnson Inc.
Please return this application in the post-paid envelope provided.

www.johnson.ca/LTC

The Long Term Care Plan is underwritten by The Manufacturers Life Insurance Company (Manulife Financial) and administered by Johnson Inc.