

The Manufacturers Life Insurance Company of New York
(hereinafter referred to as The Company)

- This form is part of the application for life insurance for the Proposed Life Insured(s).
- Authorization to Obtain Information and Notice of Disclosure of Information form NB3515NY must be used with this Questionnaire if it is being submitted on its own without the main application.
- Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s).

Please send this form with the application to:

NEW BUSINESS MAILING ADDRESS: MANULIFE NEW YORK, P.O. BOX 4608, NIAGARA SQUARE STATION, BUFFALO, NY 14240-4608

COURIER ADDRESS: MANULIFE NEW YORK, U.S. NEW BUSINESS SERVICE CENTER, 200 BLOOR STREET EAST, TORONTO, ONTARIO M4W 1E5

Name of Proposed Life Insured(s) **Life One** _____

Life Two _____

Health Questions

1. Have any of your immediate family members (parents, brothers and sisters) prior to age 65, died of or been diagnosed as having coronary artery disease, stroke or kidney disease? **Life One** - No Yes **Life Two** - No Yes

2.

| Family History | | Life One | |
|--|--------------------------------------|----------|---|
| | | Age | Give Details of Present State of Health |
| Father Mother Brothers and Sisters | L I V I N G | | |
| | | | |
| | | | |
| | | | |
| Father Mother Brothers and Sisters | D E C E A S E D | Age | Cause of Death |
| | | | |
| | | | |
| | | | |

| Family History | | Life Two | |
|--|--------------------------------------|----------|---|
| | | Age | Give Details of Present State of Health |
| Father Mother Brothers and Sisters | L I V I N G | | |
| | | | |
| | | | |
| | | | |
| Father Mother Brothers and Sisters | D E C E A S E D | Age | Cause of Death |
| | | | |
| | | | |
| | | | |

3.

a) Your Height _____

b) Your Weight _____

c) Have you had a loss of weight of more than 10 pounds within the past 12 months? No Yes - state how much and reason:

4.

a) Name and address of personal or attending doctor

b) Telephone _____

c) Date last consulted _____
Reason and any medication/treatment given _____

d) List any medications (prescription or nonprescription) you are taking currently

Life Two

a) Your Height _____

b) Your Weight _____

c) Have you had a loss of weight of more than 10 pounds within the past 12 months? No Yes - state how much and reason:

a) Name and address of personal or attending doctor

b) Telephone _____

c) Date last consulted _____
Reason and any medication/treatment given _____

d) List any medications (prescription or nonprescription) you are taking currently

Health Questions (continued) Please complete Details below for "Yes" answers.

5. So far as you know, within the last 10 years have you had or been told by a member of the medical profession that you had:

- a) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or any other disease or disorder of the heart or arteries?
- b) Diabetes or disease of any glands?
- c) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?
- d) Arthritis, gout, or any bone, joint, muscle or skin disorder?
- e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?
- f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?
- g) Prostate or testicular disease, disease of the uterus, ovaries or breasts?
- h) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?
- i) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?
- j) Cancer or tumors?
- k) An operation or admission to a hospital or any other health care facility, for observation, treatment of any illness or diagnostic tests (except for HIV or AIDS), including treadmill stress test for insurance?
- l) Any other health impairment or medically treated condition?

6. Within the last 10 years have you:

- a) used narcotics, amphetamines, cocaine or any prescription drug except in accordance with physician's instructions?
- b) undergone treatment or been advised by a member of the medical profession, licensed practitioner, or any organization regarding alcohol or drug use?
- c) used alcoholic beverages? If yes, describe frequency and quantity _____

7. Within the last 10 years have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

| Life One | | Life Two | |
|------------------------------|-----------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Details for "Yes" answers to Health Questions (If more space is required, use the Medical Questions Continuation Sheet, NB0775NY.)

| Question No. | Date | Reason and treatment given | Duration of Condition | Name, Address and Telephone Number of Attending Doctor and Hospital |
|--------------|------|----------------------------|-----------------------|---|
| Life One | | | | |
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| Question No. | Date | Reason and treatment given | Duration of Condition | Name, Address and Telephone Number of Attending Doctor and Hospital |
|--------------|------|----------------------------|-----------------------|---|
| Life Two | | | | |
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Signatures

I/We have read the statements and answers in this form and they are complete and true to the best of my/our knowledge and belief. I/We understand that they shall form part of the application for life insurance for which this medical information was required by The Company.

Signed at _____ this _____ day of _____
City/State Month Year

AGENT'S STATEMENT: I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Life Insured(s).

(X) _____
Signature of Proposed Life Insured One (Parent or Guardian, if under age 14 years and 6 months)

(X) _____
Signature of Proposed Life Insured Two (Parent or Guardian, if under age 14 years and 6 months)

(X) _____
Signature of Witness/Agent/Registered Representative

(X) _____
Consent for Juvenile Insurance of Parent or Guardian
 Father Mother Guardian