Manulife

doctors of bc

Application for Life Insurance

For the members of Doctors of BC and/or their spouse

In this application, we, us and our refer to the Manufacturers Life Insurance Company. You and your refer to the person to be insured.

Doctors of BC may be reached toll-free at 1-800-665-2262 ext. 2904 or on their website at doctorsofbc.ca.

1. Member information

A Non-smoker is 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 months.

Doctors of BC#:

Last Name: First Name: Middle Initial:

Dr. ☐ Mr ☐ Ms ☐ Mrs. ☐ Miss ☐

Former Maiden Name (if applicable): Date of Birth: (dd/mm/yy):

Province of birth: Country of birth:

Email (optional):

Mailing address (street number or name):

Apartment or Suite: City:

Province: Postal Code:

Telephone (Residence): Telephone (business):

Fax: Telephone (Cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

1.1 Contact Preference

Preferred phone number and time to contact member:

☐ Residence ☐ Business ☐ Cell

☐ Weekdays

- ☐ Morning (9:00-12:00)
- ☐ Afternoon (12:00-5:00)
- ☐ Night (8:00-11:00)

☐ Weekends

- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)
- ☐ Night (8:00-11:00)

1.2 Spouse information

Last Name: First Name: Middle Initial:

Dr. ☐ Mr ☐ Ms ☐ Mrs. ☐ Miss ☐

Former Maiden Name (if applicable): Date of Birth: (dd/mm/yy):

Province of birth: Country of birth:

Email (optional)s:

Telephone (Residence): Telephone (business):

Fax: Telephone (Cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

MBPSCS3649EN BBS 190358 - DOBC Life Ins Short App 06/20220

1.3 Spouse Contact Preference

Preferred phone number and time to contact member:

☐ Residence ☐ Business ☐ Cell

☐ Weekdays

- ☐ Morning (9:00-12:00)
- ☐ Afternoon (12:00-5:00)
- ☐ Night (8:00-11:00)

☐ Weekends

- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)
- ☐ Night (8:00-11:00)

1.4 Member occupational information

Complete this section if you are a member applying for coverage

a) Medical Specialty:

b) Date initial medical practice commenced in Canada (dd-mm-yyyy):

c) Number of hours worked per week in the practice of medicine (if less than 25, explain why):

d) Number of weeks worked per year in the practice of medicine (if less than 46 weeks per year, explain why)

1.5 Spouse occupational information

Complete this section if you are a member applying for coverage

a) Occupation: b) Amount of annual income **$**:

c) Are you actively at work for at least 20 hours per week? No ☐ Yes ☐

d) Number of weeks worked per year in the practice of medicine (if less than 46 weeks per year, explain why)

If no, confirm whether you:

i) were hospitalized in the last six months No ☐ Yes ☐

ii) can perform the six activities of daily living (bathing, dressing, feeding, continence, toileting, transferring)? No ☐ Yes ☐

2. Coverage applied for

Telephone interview

A telephone interview will be required in order to assess your application.
Manulife has selected a national support organization to conduct this interview. A carefully screened and trained interviewer will ask you a series of questions about your medical history, your doctor's name and any medications taken.
The interview will take approximately 30 minutes and be kept in strictest confidence.
The information you provide will be used solely for insurance purposes and will be sent to Manulife promptly upon completion.

*For more information about the riders, visit the Doctors of BC website at www.doctorsofbc.ca

Member Life insurance

Indicate the amount of coverage you are applying for at this time.
Maximum number of units = 100

Are you applying for: ☐ new coverage ☐ additional coverage

Level coverage	Waiver of Premium rider*	Future Insurance Option rider*
Number of units x $50,000 = **$**	☐ Yes	☐ Yes

Bill me ☐ Personally ☐ My corporation

2. Coverage applied for (continued)

Beneficiary designation

This designation supercedes any previous beneficiary designation and will apply to the entire amount of your Doctors of BC Life insurance coverage.

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary.

If no beneficiary is designated, benefits will be payable to the Estate.

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 become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Primary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Secondary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

2.1 Spouse Life insurance

Beneficiary designation

This designation supercedes any previous beneficiary designation and will apply to the entire amount of your Doctors of BC Life insurance coverage.

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary.

If no beneficiary is designated, benefits will be payable to the Estate.

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 become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Indicate the amount of coverage you are applying for at this time.
Maximum number of units = 100

Are you applying for: ☐ new coverage ☐ additional coverage

Level coverage	Waiver of Premium rider*	Future Insurance Option rider*
Number of units x $50,000 = **$**	☐ Yes	☐ Yes

Primary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Secondary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

3. Other Insurance Information

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

a) Do you have any pending or existing insurance with Manulife or any other company?

☐ Yes ☐ No If yes, provide details below

Name of applicant	Amount of benefit	Insuring company	Date of issue (mm-yyyy)
	$		
	$		
	$		
	$		

b) Will any insurance be replaced if this coverage you have applied for is issued?

☐ Yes ☐ No If yes, provide details below

Insuring company	Amount
	$
Insuring company	Amount
	$

4. 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 insurance will take effect on the date my properly completed application is received by Manulife. 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/policy issued hereunder.

I/We acknowledge my/our receipt of and agreement with the Notice on Privacy and Confidentiality 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.

Signed at (city or town): Signed at (province):

Date dd-mm-yyyy):

Signature of member: Signature of spouse:

Return completed application to: Doctors of BC Membership Department115-1665 West Broadway Vancouver BC V6J 5A4

or Fax: 1-604-638-2909

or scan and email to: insurance@doctorsofbc.ca

5 Notice of 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.

3 3 0 University Avenue, Suite 50 1 Toronto, Ontario M5G 1 R7 Telephone: (41 6) 597 -0 590
Fax: (41 6) 597 -1 1 93
Email: canada_disclosure@ mib.com

6. 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 this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the 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. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Waterloo, ON N2J 4C6.

Underwritten by The Manufacturers Life Insurance Company (Manulife).