INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

doctors of bc
British Columbia Medical Association

Accidental Death and Dismemberment Insurance Application

PERSONAL INFORMATION (PLEASE PRINT)

Name of Insured:	Last Name	First Name	Initial
Mailing Address:	City	Province	Postal Code
Date of Birth:	Month/Day/Year	MSP Billing Number:	

COVERAGE

Type of Coverage: ☐ Member Only ☐ Family Plan

Amount of Coverage:				
☐ $100,000	☐ $200,000	☐ $300,000	☐ $400,000	☐ $500,000
☐ $600,000	☐ $700,000	☐ $800,000	☐ $900,000	☐ $1,000,000

PRIMARY BENEFICIARY OR BENEFICIARIES – IN EQUAL SHARES UNLESS OTHERWISE PROVIDED BELOW

	Full Name	Relationship to Insured	%	Indicate if under age 19
1.				
2.				
3.				
4.				

CONTINGENT BENEFICIARY OR BENEFICIARIES – IN EQUAL SHARES UNLESS OTHERWISE PROVIDED BELOW

If all of my primary beneficiaries predecease me, I designate the following individual(s) as by beneficiary(ies).

	Full Name	Relationship to Insured	%	Indicate if under age 19
1.				
2.				
3.				
4.				

If you are designating a minor as a beneficiary, please complete the Trustee Section below.

DECLARATION APPOINTING TRUSTEE – APPLIES WHEN BENEFICIARY IS UNDER AGE 19

I authorize the trustee to receive any payments on behalf of the beneficiary while under the age of 19 and to apply the proceeds solely for the support, maintenance, education and benefit of such beneficiary at the discretion of the trustee.

Full Name ____________________ Relationship to Insured ____________________

AUTHORIZATION

Signature of Applicant: ____________________ Date: Month Day Year

Submit your completed form via email to insurance@doctorsofbc.ca, or via fax or mail to the number or address below.