Manulife

doctors of bc

Application for Child Critical Illness

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

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

May we correspond with you via email so that we may contact you for the application? ☐ Yes ☐ No

2. Child Information

Name (first, middle initial, last)	Relationship to member	Date of birth (dd-mm-yyyy)	Sex
	☐ child ☐ stepchild ☐ legally adopted child		☐ Male ☐ Female
	☐ child ☐ stepchild ☐ legally adopted child		☐ Male ☐ Female
	☐ child ☐ stepchild ☐ legally adopted child		☐ Male ☐ Female
	☐ child ☐ stepchild ☐ legally adopted child		☐ Male ☐ Female

3. Coverage applied for

The maximum amount of coverage available is $20,000. This amount includes any existing coverage currently in place.

Dependent Child Critical Illness (CI) insurance

Amount of new insurance applied for at this time ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

3.1 Information about your child

Complete this section if past the guaranteed issue period or if this is a request to increase coverage

Name of child: ______

______ Height ☐ ft/in ☐ cm ______ Weight ☐ gain ☐ loss

Has the child lost weight in the past 12 months? if yes, provide the details, including the amount of weight lost and the reason. ☐ No ☐ Yes

Name of Doctor (first, middle initial, last) or clinic: ______

Address: ______

City or town: ______ Province: ______ Telephone: ______

Date last consulted (dd/mm/yyyy): ______

Reason last consulted: ______

Treatment or medication prescribed and results of any tests completed: ______

______

Name of child: ______

______ Height ☐ ft/in ☐ cm ______ Weight ☐ gain ☐ loss

Has the child lost weight in the past 12 months? if yes, provide the details, including the amount of weight lost and the reason. ☐ No ☐ Yes

Name of Doctor (first, middle initial, last) or clinic: ______

Address: ______

City or town: ______ Province: ______ Telephone: ______

Date last consulted (dd/mm/yyyy): ______

Reason last consulted: ______

Treatment or medication prescribed and results of any tests completed: ______

______

Name of child: ______

______ Height ☐ ft/in ☐ cm ______ Weight ☐ gain ☐ loss

Has the child lost weight in the past 12 months? if yes, provide the details, including the amount of weight lost and the reason. ☐ No ☐ Yes

Name of Doctor (first, middle initial, last) or clinic: ______

Address: ______

City or town: ______ Province: ______ Telephone: ______

Date last consulted (dd/mm/yyyy): ______

Reason last consulted: ______

Treatment or medication prescribed and results of any tests completed: ______

______

3.1 Information about your child (continued)

Name of child:

Height ☐ ft/in ☐ cm   Weight ☐ gain ☐ loss

Has the child lost weight in the past 12 months? if yes, provide the details, including the amount of weight lost and the reason. ☐ No ☐ Yes

Name of Doctor (first, middle initial, last) or clinic:

Address:

City or town: | Province: | Telephone:

Date last consulted (dd/mm/yyyy):

Reason last consulted:

Treatment or medication prescribed and results of any tests completed:

3.2 Family History

If adopted, check here and continueto section 3.3: ☐

a.) Have any of your child's biological parents, brothers or sisters been diagnosed before age 65 with any of the following conditions: heart disease, stroke/TIA, cancer, diabetes, high blood pressure, high cholestorol or Parkinson's disease?

☐ Yes ☐ No ☐ Unknown   • If yes, provide details in the chart below

b.) Have any of your child's biological parents, brothers or sisters ever been diagnosed with Huntington's chorea, polycystic kidney disease, 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, kidney disorders or retinitis pigmentosa?

☐ Yes ☐ No ☐ Unknown   • If yes, provide details in the chart below

Relationship to family member	**Condition or impairment (if cancer, provide details, including the type and location)**	**Age at onset**	**Age if living**	**Age at death**

3.3 Medical History

IMPORTANT: Any reference to testing, tests, test results, or investigations 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 any of your children ever had any indication of or been treated for conditions involving any of the following:	Yes	No
1. heart murmur, disease of heart or blood vessels?	☐	☐
2. diabetes, elevated blood sugar, thyroid disorder or other endocrine disorder?	☐	☐
3. hemophilia or other bleeding disorders?	☐	☐
4. cancer, tumor, or any other growth or malignancy?	☐	☐
5. disease or disorder of the kidney?	☐	☐
6. hepatitis (including hepatitis carrier state) or liver disorder?	☐	☐
7. epliepsy, disorder of the brain, multiple sclerosis,cerebral palsy, muscular dystrophy or any other congenital disorder or disease of the nervous system?	☐	☐
8. asthma, cystic fibrosis, persistent cough, difficulty breathing or hoarseness?	☐	☐
9. disorder of the eye, ear, nose, throat or mouth, blindness or deafness (exclude routine checkups where no follow-up is required, such as tonsillectomy, adenodectomy, sinusitis, or any disorder requiring eyeglasses, contact lenses, or ear tubes)?	☐	☐
10. depression, anxiety, attention deficit disorder or hyperactivity?	☐	☐
11. arthritis, disorder or disease of the muscles, joints, limbs, back, bones or paralysis?	☐	☐

3.4 Medical History (continued)

Questions	Child's name	Date (mm-yyyy)	Details, diagnosis if known, treatment, history, reason for tests, results of tests, recurrence, names and address of all attending doctors

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. 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/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:

Signature of child to be insured if age 16 or over:

Return your completed application to:

Doctors of BC Insurance
Department 115 - 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.

330 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).

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