Manulife

doctors of bc

Application for Critical Illness Insurance

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#: ☐ New member ☐ Life event

Date of life event (dd/mm/yyyy): Life event:

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

1.2 Member Contact Preference

Preferred phone number and time to contact member:

☐ 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)

1.3 Spouse information (if applying for Spouse Critical Illness insurance)

*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.

Last Name: First Name: Middle Initial:

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

Province of birth: Country of birth:

Email (optional):

Telephone (Residence): Telephone (business):

Fax: Telephone (Cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

1.4 Spouse Contact Preference

Preferred phone number and time to contact member:

☐ 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)

1.5 Child information (if applying for Child Critical Illness insurance)

If additional space is required, attach a signed and dated sheet of paper with the required child information

Last name	First name	Date of birth (dd/mm/yyyy)	Sex
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

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.

Member Critical Illness insurance
Minimum $50,000, Maximum $500,000, in units of $1 0,000

Amount of new insurance applied for at this time $ | Waiver of Premium rider: ☐ Yes

Spouse Critical Illness insurance
Minimum $50,000, Maximum $500,000, in units of $1 0,000

Amount of new insurance applied for at this time $ | Waiver of Premium rider: ☐ Yes

Dependent Child Illness (CI) insurance
Amount of new insurance applied for at this time ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

3. Occupational information

Medical specialty	Spouse's occupation
Average number of hours you work per week	Average number of hours your spouse works per week
If less than 20, please provide details	If less than 20, please provide details

4. Other Insurance Information

Complete this section if applying for more than $50,000 of coverage.

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
	$

5. 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:

Return completed application to:
Doctors of BC Insurance Department or Fax: 1-604-638-2909 or scan and email to: insurance@doctorsofbc.ca
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

6. 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 501 Toronto,
Ontario M5G 1 R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

7. 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.

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