

Application to exercise future insurance option

The Doctors of BC Life Insurance Plan

1. General information

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# _____

Last Name: _____ First Name: _____ Middle Initial: _____

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

Address (street number and name) _____ Apartment or Suite: _____

City: _____ Province: _____ Postal Code: _____

Email address (optional): _____

Telephone (daytime): _____

Male Female

2. Coverage applied for

Amount of additional insurance applied for **\$50,000** : _____

3. Declaration of eligibility

You can only exercise your Future Insurance Option to increase coverage within 60 days of one of these events

I am eligible to apply for this coverage, without evidence of insurability, for the following reason:

Attainment of age: 25 30 35 40 45 50 55

Date (dd-mm-yyyy)

Marriage or eligible common-law relationship _____

Birth or legal adoption of a child _____

Completion of residency _____

Completion of medical school _____

4. Occupational information

Occupation: _____

Are you actively at work at least 25 hours per week? Yes No

If no, answer the following questions:

a. Were you hospitalized in the last six months? Yes No

If yes, provide details:

b. Are you able to perform all the usual duties of your normal occupation? Yes No

If no, provide details:

5. Declaration and authorization

I (the Member) 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 shall render any insurance issued pursuant to this application voidable at the instance of the insurer. 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 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 the insurance coverage, 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 acknowledge my receipt of and agreement with the Notice on Privacy and Confidentiality.

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

Date (dd-mm-yyyy): _____ Signature of insured: _____

Return completed application to:
Doctors of BC Insurance Department
115-1665 West Broadway
Vancouver BC V6J 5A4

Fax: **1-604-638-2909**
Scan and email: **insurance@doctorsofbc.ca**

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.

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