Manulife

doctors of bc

Application to exercise the guaranteed insurability benefit rider

The Doctors of BC Professional Expense Insurance Plan

1. Member 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# **MSP#**

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 (Residence): Telephone (Cell):

☐ Male ☐ Female

1.2 Business Information

Business address (street number and name): Apartment or Suite:

City: Province: Postal Code:

Telephone (Business): Fax:

2. Coverage applied for

In $100 units (see letter for available amounts)
Elimination period cannot be shorter than shortest period already in force

Amount of additional monthly benefits applied for at this time: $

Elimination period applied for: ☐ 14 days ☐ 30 days ☐ 60 days ☐ 90 days

3. Occupational information

Note: Any amount approved during a period of disability will apply only to any new disability.

a. Medical Specialty:

b. Are you self-employed? ☐ Yes ☐ No

If yes, business structure
☐ Sole proprietor ☐ Partnership ☐ Corporation % of ownership

If no, name and address of employer:

3. Occupational information (continued)

Note: Any amount approved during a period of disability will apply only to any new disability.

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

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

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

f. Are you now disabled and/or on claim and/or satisfying an elimination period? ☐ Yes ☐ No

If yes, indicate the date you became disabled (dd-mm-yyyy):

4. 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.

Do you have any pending or existing insurance with Manulife or any other company? ☐ Yes ☐ No

If yes, provide the details below:

Amount of Benefit	Insurance Company	Date of issue (mm-yyyy)	Benefit period	Taxable Benefit
$				☐ Yes ☐ No
$				☐ Yes ☐ No

Will any Disability insurance be replaced if this application is approved? ☐ Yes ☐ No

If yes, provide the details below:

Insuring Company: Amount: $

5. Financial Information

What is your average monthly professional expenses for the prior calendar year? $

Do you have any unearned income not dependent on your ability to work in excess of $30,000 or 15% of your insurable Net Annual Earned Income?

☐ Yes ☐ No

if yes, amount of unearned income: Source of unearned income:

Have you ever declared, or are you contemplating bankcruptcy? ☐ Yes ☐ No

If yes, date of discharge (dd-mm-yyyy):

6. 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 member:

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**

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.

Underwritten by The Manufacturers Life Insurance Company (Manulife).