Manulife

doctors of bc

Application for Disability Insurance

For the members of Doctors of BC

In this application, we, us and our refer to the Manufacturers Life Insurance Company. You and your refer to the person to be insured.

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#: | MSP number:

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

2. Contact Preference

Preferred phone number and time to contact member:

Residence ☐ Business ☐ Cell

☐ Monday to Friday
- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)
- ☐ Evening (5:00-10:00)

Saturday
- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)

☐ Sunday
- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)

3. Member occupational information

a) Medical Specialty:

b) Are you self-employed? ☐ No Yes Both

If yes, business structure

☐ Sole proprietor ☐ Partnership Corporation _____ % ownership

If no, name of employer

c) Date initial medical practice commenced in British Columbia (if within the last 2 years) (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) Have you changed your job duties, location and/or hours of work in the past 2 years, or do you contemplate such changes within the next 12 months? No ☐ Yes

If yes, please describe

4. Coverage applied for

If you are an eligible member and applying within 6 months of beginning initial medical practice in the province of British Columbia, and have not been issued coverage under group policy 59999, you are eligible for $1500 of monthly Disability Income Benefit with a 90 day elimination period with providing evidence of insurability.

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 Disability insurance
Minimum $500, Maximum $25,000, in units of $100

Amount of insurance applied for at this time (excluding existing Doctors of BC coverage, if any)

$ 28 days	$ 60 days	$ 90 days	$ 120 days

Indicate any optional riders** applied for:

☐ Own Occupation
- 3% Cost of Living Adjustment
- 6% Cost of Living Adjustment
- Guaranteed Insurability Benefit

Retirement Protection
- ☐ $500 monthly contribution benefit
- $1,000 monthly contribution benefit
- ☐ $1,500 monthly contribution benefit

Physicians Disability insurance (PDI)

☐ Yes, I am applying for PDI coverage

The provincial government provides funding for this benefit. The premium paid on your behalf is a taxable benefit to you.

**For more information about the riders, visit the Doctors of BC website at www.doctorsofbc.ca/insurance

5. Financial information

	Current year-to-date		Actual last year
	From (mm-yyyy)	To (mm-yyyy)	(mm-yyyy)
Gross annual income before business expenses (A)	$		$
Less annual total of all your business expenses (B)	$		$
Net annual income before taxes (A) - (B)	$		$

Is any portion of your income from a salaried position? No ☐ Yes ☐ If yes, provide salary **$**

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? No ☐ Yes ☐

If yes, amount of unearned income **$** Source of unearned income

Have you ever declared or are you contemplating bankruptcy No ☐ Yes ☐

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

6. Income documentation for Disability insurance

f you are applying for Disability insurance that exceeds $ 10,000 per month from all sources, financial documents are required to confirm your income (unless you are in fellowship program or are in your first 2 years of practice)

The following income documentation will be required depending on your business structure.

☐ I am enclosing the following documentation.

Employed (salaried)
- Most current T4 or,
- Income tax return - T1 (pages 1-4)

Sole Proprietor or Partnership
- Income tax return - T1 (pages 1-4) and,
- Statement of Business or Professional Activities (T2125)

Incorporated
- Most current T4 or,
- Personal income tax return - T1 (pages 1-4) and,
- Busness Financial Statements of the Corporation

7. Accountant information

☐ I am enclosing the required documentation, **or**

☐ Contact my accountant to obtain the required income documentation

Accountant last name: | First name:

Mailing address (street number or name): | Apartment or Suite:

City: | Province:

Postal Code: | Telephone (Residence):

Fax: | Email (optional):

7. 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.

a) Do you have any pending or existing insurance with Manulife or any other company?

☐ Yes ☐ No If yes, provide details below

Amount of benefit	Insuring company	Date of issue (mm-yyyy)	Benefit period
$			
$			

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 $

8. 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 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 hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

I acknowledge my receipt of and agreement with the Notice on Privacy and Confidentiality and Notice of Exchange on Information.

If my application is approved, I 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:

Return completed application to:
Doctors of BC Membership
Department115-1665 West
Broadway Vancouver BC V6J 5A4

or Fax: 1-604-638-2909

or scan and email to: insurance@doctorsofbc.ca

9. 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 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

10. 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).