Manulife

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Application for student membership and insurance for first year medical students

For students enrolled in the Faculty of Medicine at the University of British Columbia

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

1. General information

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:

Address: Apartment or Suite: SIN:

City: Province: Postal Code:

Preferred telephone number: Email (optional):

Date you started medical school (dd-mm-yyyy)

Date you expect to graduate (dd-mm-yyyy)

Medical school site: ☐ Vancouver (VFMP) ☐ Victoria (IMP) ☐ Prince George (NMP) ☐ Kelowna (SMP)

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

*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.

2. Doctors of BC/CMA membership dues

Your medical student membership is provided compliments of the Doctors of BC and covers both Doctors of BC and CMA membership for all consecutive years you are enrolled as a medical student. You may cancel at any time by notifying Doctors of BC Membership in writing of your cancellation.

I hereby apply for a membership in Doctors of BC, and agree to abide by the By-laws, Rules and Regulations of the Association.

I hereby agree to provide my Social Insurance Number for administrative purposes.

Signed at (city or town): _____ Date (dd-mm-yyyy):

3. Insurance coverage included

Note: Life and disability insurance will be provided to you for all four years of medical school.

Disability Insurance

Disability income:
$1,500 Monthly Benefit COLA & GIB included
HIV/Hepatitis B/C Benefit

By checking this box , ☐ I am opting out of this program and I understand I will not be insured for Disability or Life insurance. For full coverage details, see: www.doctorsofbc.ca/member-services/insurance-student-life-disability

Life insurance - $100,000 Level Term Insurance

3. Insurance coverage included (continued)

Beneficiary designation

This designation supercedes any previous beneficiary designation and will apply to the entire amount of your Doctors of BC Life insurance coverage.

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary.

If no beneficiary is designated, benefits will be payable to the Estate.

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Primary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Secondary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

4. Other insurance Information

Note: Do not cancel an existing coverage until the coverages you have applied for has been approved.

Do you currently have Disability insurance or have you concurrently applied for any Disability insurance coverage provided by individual or group policies, or employment contracts/partnership agreements?

☐ Yes ☐ No If yes, provide details below

Amount of benefit	Insuring company	Date of issue (mm-yyyy)	Elimination period (ie. 90 days)	Benefit period (ie. to age 65)	Taxable
					☐ Yes ☐ No
					☐ Yes ☐ No

Will any insurance be discontinued if this coverage you have applied for is issued?

☐ Yes ☐ No If yes, provide details below

Insuring company	Policy number	Amount
		$
Insuring company	Policy number	Amount
		$

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 including misstatement of smoker status shall render the insurance voidable at the instance of the insurer, and that suicide within two years of the effective date is a risk not covered. 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 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 .
I will receive a certificate specifying the coverage provided and the main certificate provisions.

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

Signature of member: _____

Mail 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

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).